Clinical Lecture
ON AN
OUTBREAK OF RHEUMATIC PNEUMONIA.

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GENTLEMEN,—It is generally allowed, I think, that pneumonia does sometimes occur in the course of acute rheumatism. But there is a very wide difference of opinion as to its frequency and importance. Some authorities speak of it as one of the rarest of phenomena; others as a not very uncommon complication of rheumatic fever. I confess that until a few months ago I should have regarded rheumatic pneumonia as a comparatively rare affection; and, looking back upon the records of hospital cases, I find this opinion justified by previous experience. By the kind help of Dr. Cockey, the Registrar, I have obtained the statistics of the last three years, showing the incidence of pericarditis, pleurisy, and pneumonia. I find that from Oct. 1st, 1884, to March, 1887 (two years and a half), the number of cases of acute rheumatism admitted into St. Mary's is 157. Of these pericarditis occurred in 8 cases, pleurisy in 1 case, and pleuro-pneumonia in 1 case. So that both pleurisy and pneumonia have been extremely rare events, and pericarditis not common, occurring in only 5·09 per cent. of the cases. Yet suddenly our experience in this respect has been altered in a startling manner. During the past summer case after case occurred in which extensive pneumonia was developed during the course of rheumatic fever, pericarditis being also more frequent than before. Taking the statistics of the three months, June, July, and August last, we have: Total number of cases of acute rheumatism, 26; pericarditis alone occurred in 1, pericarditis and pneumonia in 5, pericarditis and pleurisy in 1, and pneumonia alone in 1; so that in this special period 26 per cent. had pericarditis, and 23 per cent. had pneumonia. You will observe that in every case but one pneumonia was associated with pericarditis; in some there was slight pleurisy also, though in all but one instance it was a purely minor and unimportant feature.

CASE 1[1].—The first case which attracted my attention was that of Joseph P——, aged eighteen, an engine cleaner, admitted on June 10th, 1887, with acute rheumatism. Both knees, the left ankle, and the right elbow were red, swollen, and tender. It was the patient's first attack but he came of a rheumatic family, his mother and sister both having suffered from acute rheumatism. The temperature was 100·8° on admission, and it soon rose to 102·6°. In addition to the joint pain the patient complained of stitch in the left side. On examination of the chest, the apex beat of the heart was found in the fifth space, about half an inch outside the nipple. The area of dulness was increased towards the left. The only sign of valve trouble was a prolongation of the first sound at the apex, and a doubling of the second sound there. The sounds were feeble. There was no friction. The movements of respiration were somewhat irregular, and there was pain on taking a deep breath; no friction was audible, and the stitch was referred to intercostal rheumatism. Percussion was good all over; the respiratory sounds free and natural, except for a slight bronchial wheeze in front. The patient was given salicylate of soda after the usual fashion, but without much effect on the temperature, although the pains were relieved. On June 18th, or eight days after admission, the patient complained of pain at the cardiac region. The pulse had quickened, and the respirations rose to 72. On auscultation, to-and-fro friction sounds were heard at the third left space. Leeches were applied, with the effect of giving great relief, but the pericarditis spread to the whole of the heart's surface, the friction sounds becoming general. On June 24th, six days after the supervention of pericarditis, and while the friction sounds were still fully audible, a slight increase in the number of respirations was observed, also a slight rise of temperature, which had been steadily falling previously. As the pericardial signs were subsiding, the probability of some fresh cause of disturbance elsewhere suggested itself. The chest was accordingly examined behind as well as in front, a duty too often omitted on account of the pain and distress caused to the patient by the necessary moving. This disclosed marked dulness at the angle of the scapula on the left side, with increase of vocal vibration and resonance and tubular breathing of great intensity. On the right there was some impairment of resonance and breath sounds, and slight moist crepitations. These signs gradually subsided. The temperature fell gradually to normal on July 11th, and on the 25th the man was allowed to get up, as being convalescent. Six days later—the 31st—there came another rise of temperature, followed by fresh pain in the joints and renewed pericardial friction, and fresh signs of pneumonic consolidation at the left base—viz., dulness, crepitation, bronchial breathing, and increased vocal vibration. There was never any cough, never rusty sputum at any time. The symptoms again declined, and the patient left, convalescent, the only physical signs remaining being slightly impaired resonance at the left base, enfeebled breathing, increased area of cardiac dulness, and soft systolic apex murmur.

I will ask you carefully to note here these points: 1. The pneumonia came on with pericarditis, apparently arising later (six days after its commencement), and the relapse of pneumonia with the return of pericarditis and of joint affection. 2. The patient had no antecedent heart affection, but the mitral valve became affected during this attack. 3. There was nothing to attract attention specially to the lung mischief; no cough, no rusty sputum, nothing but the rise of temperature and quickened respiration. 4. The left lung was the one chiefly involved. 5. The disease declined by lysis.

With this youth, in this same Albert ward, at the same time, were two other patients suffering from this same affection, acute rheumatism—two boys, aged twelve and thirteen years respectively. Each of them had pericarditis, likewise accompanied by pneumonia.

CASE 2.—The first, Fred. P——, was admitted on June 14th (four days before the last case) with swollen, tender joints, this being the fourth attack. On examination, he was found to have a double aortic murmur, a systolic mitral murmur at the apex, and increased area of impulse and dulness, indicating hypertrophy and dilatation of the heart, due to affection of the valves in previous attacks. The respiratory signs were found to be normal, with the exception of slight dulness at both bases behind, want of vocal fremitus there, and enfeebled breathing; these signs were limited to the extreme bases, and were slightly marked. The temperature was 100°. Under ten grains of salicin and fifteen grains of citrate of potash every four hours, there was some relief of joint pain, but the temperature rose to 102°. On the 16th (two days after admission) auscultation disclosed a friction sound at the base of the heart, which was clearly pericardial. Improvement took place, although the friction sound developed, the temperature falling gradually to normal by the 23rd. On the evening of that day, however, it was noticed that the temperature was again rising to 101·2° without obvious reason. Pain in the shoulder still continued, and pericardial friction was still audible, but there was no sign of its extension. Two days later deficient respiratory movement of the left side of the chest was observed. There was no cough, no expectoration, nothing except the impaired chest movement, to suggest lung trouble; but the house physician (Mr. Batchelor), mindful of our experience in the preceding case, carefully examined the chest, and found behind, below the angle of the left scapula, marked dulness, loud tubular breathing, some fine crackling, and increased vocal vibration—signs, in a word, of pneumonic consolidation of the base of the left lung. This condition had become still more extensive when I examined the boy's chest two days later. There was also evidence of some pleuritic effusion at the extreme right base, but this never assumed any importance. In a few days the temperature fell gradually as the physical signs subsided, and reached normal on July 5th—i.e., on the twelfth day after the beginning of the pneumonic rise.

Here, again, I would ask you to note, as in the preceding case—1. That the pneumonia accompanied the pericarditis,

[1] For the records of these cases I am largely indebted to my clinical clerks, Messrs. Griffiths, Graves, and Daniel, and Mr. Batchelor, my house physician, to all of whom my best thanks are due.

arising about seven days later, and marking a distinct temperature wave on the chart. 2. The patient had extensive valvular disease, both aortic and mitral, with great consequent dilatation and hypertrophy. 3. The absence of signs, such as cough, rusty sputum, or any special respiratory disturbance, suggestive of lung trouble. 4. The left lung was the one affected. 5. The decline was by lysis.

CASE 3.—The second boy, W. B——, aged thirteen, was in the ward at the same time with a second attack of the same affection, acute rheumatism. He also had pericarditis, double pneumonia, and some pleurisy in almost exactly the same manner as the preceding patient. He was admitted on June 17th, three days later than Case 2. On examination he was found to have double aortic disease and mitral regurgitation, with considerable hypertrophy and dilatation, the result of the former attack. Pericardial friction was discovered at the base. I need not give the details of the case, for I have no concern now except with the main points. It is sufficient to say that the pericarditis fully developed in the course of the week; that on the 24th, or seven days after admission, signs of pneumonia—crackling, tubular breathing, dulness, increased vocal vibration—were observed at the base of the left lung. There was no cough, rusty sputum, or special sign of respiratory trouble. There was a slight rise of temperature—viz, from 99° to 101·6°. The physical signs, limited to the extreme base at first, quickly developed to consolidation of the lower half of the left lung. The pneumonic condition subsided by lysis about the eighth day. A few days later (July 5th) came a fresh rise of temperature and a similar implication of the right lung, followed by recrudescence of pneumonia in the left; then signs of dry pleurisy at the right base (double friction sound); then gradual recovery, every pulmonary sign having cleared away before the patient's discharge on August 13th.

Note here, again, a similar series of clinical events to those of the two preceding cases:—1. The pneumonia came on with pericarditis, appearing about seven days later. 2. The patient had extensive valvular disease, both aortic and mitral, with great resultant hypertrophy and dilatation. 3. There was no cough, no rusty sputum, no special pulmonary symptoms of any kind, except the physical signs. 4. The condition was discovered before any large portion of lung was involved, owing to more frequent examination of the posterior chest, and the crepitations of the early stage were present. 5. The left lung was first involved, the right subsequently, and then the left again affected. 6. The temperature fell slowly by lysis.

Immediately following these three cases there came a fourth.

CASE 4.—Phœbe H——, aged twenty-two, a laundress, was admitted on July 4th, 1887, with a third attack of rheumatic fever. On examination she was found to have serious double aortic and double mitral disease, with extensive dilatation and hypertrophy. She complained of palpitation and dyspnœa. The pulse was collapsing, marking chiefly the aortic regurgitation. The pulmonary sounds were normal, with the exception of some harshness at both sides in front. The following day, however, bronchial breathing, fine crepitation, dulness on percussion, and increased vocal vibration were detected at the left base behind. There was no cough, no rusty sputum, or expectoration of any kind. Three days later similar signs were found at the right base. The signs increased, the temperature rose, the heart began to fail more and more, and she died on July 10th, the sixth day after admission. Unfortunately it was found impossible to obtain a post-mortem examination.

Note here—1. No pericarditis existed, or rather there was no evidence of it, as in all preceding cases. 2. The patient had double aortic and double mitral disease, with resultant dilatation and hypertrophy. 3. There was never any cough, expectoration, or other general symptom of pulmonary trouble. 4. The signs of pneumonia were found early, before the lung was extensively implicated, and the crepitus of the first stage was present. 5. The patient died of double pneumonia.

CASE 5.—The next case is again that of a boy. Thomas D——, aged eleven, was admitted on Aug. 25th with a third attack of rheumatic fever. There was a loud, rough systolic murmur at the apex, a greatly accentuated second sound over the pulmonary artery, and increased impulse and area of cardiac dulness. A loud double pericardial friction sound was audible at the base. Two days later (July 27th) signs of pneumonia were discovered at the left base: dulness bronchial breathing, increased fremitus, but no crepitation. There was no cough or expectoration. On the 30th these signs had developed; the breathing was intensely tubular, and fine crepitations were audible. On Sept. 1st similar signs were also observed at the right base, with a fresh rise of temperature. By the 18th the double pneumonia declined, and the temperature became normal by lysis on the 14th. On the 19th there was a fresh rise of temperature (100·8°), and a double pleural friction heard at the base of the left lung. This was followed by gradual effusion, and this again by steady reabsorption and gradual convalescence.

Note here again—1. That the pneumonia accompanied pericarditis, arising later. 2. The patient had serious mitral regurgitation with hypertrophy. 3. There was neither cough nor expectoration. 4. The signs were found early, and included the crepitations of the first stage. 5. The left lung was first and chiefly involved, the right later and in less degree, and the pleurisy of the left side came long after the pneumonia. 6. The pneumonia declined by lysis.

CASE 6.—The last case I have to bring before you is one now in the Alexandra ward. Adela F——, aged nineteen, servant, was admitted on Sept. 29th with a first attack of rheumatic fever. She was treated in the usual way with salicylate of soda, twenty grains every hour for four doses, and then every three hours. After five doses in twenty-four hours she became slightly delirious and restless. The mixture was discontinued (Oct. 1st), quinine and citrate of potash being substituted, but at times she became quite maniacal during the night. Next morning she was quieter, and the delirium was attributed to salicylic acid, although there were no other symptoms of toxic effect, such as deafness, vomiting, or purging. Next day (Oct. 2nd) she complained of pain in the right side, when pleuritic friction was heard at the extreme base. There was no cough or expectoration. On Oct. 3rd the temperature went up to 103·8°; the pulse rose to 120, excited and feeble; the respirations, which had been only 17, ran up to 40. Next morning extensive pericardial friction was heard, and signs of effusion at the lower right chest, but the left lung was noted clear. It was not until the 10th, or six days later, that distinct signs of pneumonia developed in the left lung. There appeared intense tubular breathing, fine dryish crepitus, dulness, and increased vocal vibration. The chest had been examined daily. The signs of pleuritic effusion at the right remained unchanged during the development of the left pneumonia; as the pericarditis declined a loud mitral murmur became audible. The signs of consolidation and pericardial friction gradually lessened; the temperature fell day by day, and reached the normal on the 25th. The joint affection continued to be severe throughout the period of development of pericarditis and pneumonia. The mitral murmur remained.

I would draw your attention in this case to almost the same points as before:—1. The pneumonia occurred in conjunction with pericarditis, arising somewhat later. 2. There was no previous valvular affection of the heart, but a mitral murmur was developed during the attack. 3. There was no cough or expectoration. 4. The first signs of pneumonia were noted six days after the commencement of the pericarditis, and the crepitations of the first stage were present. 5. The left lung was the seat of pneumonia, the right of pleurisy. 6. The temperature fell by lysis.

Such, gentlemen, is the short history of this curious outbreak of pneumonia and pericarditis during the course of rheumatic fever: a series of six cases, four of them contemporaneous in June and July, the others following closely after, and all exhibiting a remarkable resemblance to each other in clinical features. They coincide with singular closeness in nearly every particular.

1. Take first the relation between the pneumonia and the pericarditis. In every case but one (that of the girl Phœbe H——), pneumonia followed on pericarditis. In the case of Phœbe H——, where pericarditis was not noted, it is just possible that it may have existed without signs in the shape of friction or effusion, for she had had rheumatic fever twice before, and may have had previous pericarditis and adherent pericardium. If this were so, the cardiac action would have been embarrassed, although in less degree, perhaps, than during active inflammation with recent exudation. In the five cases in which pneumonia supervened upon pericarditis, it came on after a definite interval. Thus in two cases it was six days, and in two seven days, after the first sign of pericarditis. In the remaining case (Case 5) the pericarditis existed fully developed at the time of the patient's admission, the pneu-

monia appearing two days later. The exact duration of the pericarditis was in this instance unknown; but from the physical signs it must have existed for some days. It is probable, therefore, that the interval between the onset of pericarditis and pneumonia was almost identical with that observed in the other instances.

2. In four out of the six cases there was old-standing valvular disease of the heart of great gravity; in three of these aortic stenosis and regurgitation, combined with mitral regurgitation. In the remaining two cases a mitral regurgitant murmur developed during the attack.

3. The next special feature to which I would ask your attention is that these cases of rheumatic pneumonia differ from ordinary lobar pneumonia in certain leading signs and symptoms. In the first place, in every instance, without exception, the pneumonia commenced in, and chiefly affected, the lower lobe of the *left* lung, instead of the right, as most frequently in ordinary pneumonia.[2] In three cases (3, 4, and 5) there was a similar affection of the right, but this was always later in date.

In the next place, there was none of the hacking cough which is often a prominent symptom in pneumonia, and not only was there no *rusty* sputum, but expectoration, like cough, was altogether wanting. Another peculiarity noted by Dr. Sturges in his valuable monograph on Pneumonia—viz, absence of the usual signs of the first stage, and especially of fine crepitation—was also observed in the first case. The consolidation was complete when first found; there was no crackling. Yet this sign of the early stage was present in the same case during a relapse, and in all the others at first. I imagine that its absence in the primary attack in Case 1 was due to the disease having already passed out of the first stage before the state of the lung was examined, and this may possibly be the explanation of a similar absence in other instances also. It must be allowed, however, that crepitation was less abundant and well marked than in most cases of ordinary pneumonia.

And lastly, the temperature fell gradually in all these cases; the disease ended by lysis, not by crisis, as in about one-half the cases of true pneumonia. The concurrent arthritis and pericarditis would, however, tend to modify the true pneumonic chart.

Now this difference in the physical signs and symptoms in these cases, as compared with those of an ordinary croupous pneumonia, points to some difference in the morbid condition of the lung. The state of the air cells and bronchioles must differ largely from that in which there is irritant cough and free blood-stained secretion. In these cases the consolidation is probably due, as Dr. Sturges has suggested,[3] to a rapid transudation of fibrin from blood in a highly fibrogenous condition circulating under conditions of special mechanical difficulty. As pointed out before, in four of the present series of cases there was serious disease of the mitral valve to begin with; in the two remaining cases a mitral murmur had developed during the attack. In three cases there was double aortic disease in addition to the mitral affection, and in four pericarditis. The defect in the mitral valve would cause obstruction to the venous return from the lungs; pericarditis would cause serious embarrassment of the heart's action, and possibly coexistent myocarditis serious weakening of its muscular power. The concurrence of rheumatic hyperinosis would favour the fibrinous outpour.

But although these conditions may explain the ready occurrence of pneumonic exudation in these cases, and the variation in the symptoms and physical signs from the normal type, and also perhaps the more ready production of pericarditis, they throw no clear light upon the transfer of incidence from the right lung to the left. Of this feature I see no satisfactory explanation. But further granting that the heart affection and rheumatic state were powerful predisposing causes of the pericarditis and pneumonia, there must have been yet another factor, some immediate exciting cause for this exceptional outbreak. Mitral disease of the heart and the acute rheumatic state are constantly coexistent without producing pneumonia or pericarditis. Or does the explanation lie in the fact that pneumonia is, after all, really more common in the course of acute rheumatism than is supposed? and is the fact of its being rarely observed due to its being overlooked? The absence of signs such as cough and rusty sputum, and the concurrent pericarditis, would tend to lead suspicion away from the lungs, while the reluctance to inflict the pain necessarily involved in a physical examination of the posterior portion of the chest in the case of patients to whom every movement is distressing often leads to its omission. This may account for some instances of oversight; but it is impossible to believe that it would account for all if such inflammation of the lung were really frequent. There can be no doubt that the occurrence of pneumonia in such a series of cases is exceptional, and the extreme frequency of pericarditis, which was altogether excessive and abnormal, supports this view. To what determining cause, then, must the outbreak be ascribed? It may have been due to some exceptional virulence of the "rheumatic poison," but of this there was no evidence. There was no abnormal affection of joints, no hyperpyrexia. I am loth to admit this begging of an easy solution. It was clearly not the result of treatment, for that was most varied; and, besides, all the remedies have been repeatedly given in similar cases without any such disastrous results. I am inclined to refer it to a much more simple and commonplace cause. In the past summer, at the season when this outbreak occurred, the weather was excessively hot and the wards were ventilated with unusual freedom. You know how susceptible to external cold these rheumatic patients are; how constantly getting out of bed too soon causes a relapse. In the profuse perspiration which attends acute rheumatism a chill would readily be produced by the strong currents of cold air which stream in from windows and ventilators, and this may reasonably be supposed to have determined the inflammation of pericardium and lung or pleura in the existing physical condition of organs so favourable to its production.

From this series of cases one or two useful practical hints may be deduced. The first is this: Whenever pericarditis arises in the course of rheumatic fever, or whenever an unexplained rise of temperature, or persistence of high temperature, or acceleration of respiration occurs, make a careful examination of the physical condition of the chest, behind as well as in front. Secondly: Always protect your rheumatic patient carefully against draughts by a canopy over the bed. I have obtained a number for use in the wards in these cases and in others, such as Bright's disease and bronchitis, where surface chills are especially noxious. Lastly: Where pericarditis and pneumonia arise in the course of acute rheumatism, avoid the use of drugs such as salicylate of soda and aconite—marked cardiac depressants. In such cases one especial source of danger lies in heart failure. Use, therefore, salicin in preference to salicylic acid, or, better still, quinine in full doses of from three to five grains every four hours. With this citrate of potash may be combined, with the addition of citric acid for the solution of the quinine.

[2] This preference for the left lung appears also in three cases of pneumonia associated with rheumatism, recorded by Dr. Sturges in his monograph on Pneumonia (p. 70-73). In two it was limited to the left; in the remaining one it was double, although most marked in the right. In another case where pneumonia followed pericarditis, but not certainly rheumatic, the left lung was alone affected.

[3] Pneumonia, pp. 76, 77.

Post-Graduate Lecture
ON
SYPHILIS AND ITS TREATMENT.

Delivered at Charing-cross Hospital.

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THE subject of syphilis is so important, not only in its relation to the health of the individual, but also on account of its effects on the community at large, that its consideration is one worthy of all attention. It is a disease highly contagious, strongly hereditary, and most disastrous in its results when improperly treated or neglected. I will not weary you with the oft-trodden ground as to the origin and history of syphilis, with which no doubt you are all more or less familiar, and which in the daily routine of practice is but of little value, but will pass on without further remarks to the practical treatment of the subject.

The first question we have to ask ourselves is this: What is syphilis? And I would answer that it is a disease, the result of a poison which is communicable only by *actual*

contact or by *hereditary transmission*, and that our present knowledge appears to lead in the direction of its being some form of bacillus characterised by a period of incubation, and then followed, if not treated, by a regular course of symptoms. This period of incubation is not, like many others, of a definite nature, but varies in duration. In my opinion this largely depends upon the seat of the primary lesion, and in consequence upon the local difficulty the virus has of entering the blood. I propose, then, to divide the consideration of our subject into the various recognised stages of the disease, and to treat it as being represented by the primary, secondary, and tertiary stages or forms, taking the hereditary manifestations as a separate and distinct class.

Primary sore.—This occurs when there has been actual contact with the virus, and its seat is usually to be found in those parts in which an abrasion or rupture is liable to occur. Hence we see it usually under the prepuce, towards the frænum and on the fourchette in the male, and on the edges of the vulva and orifice of the vagina in the female. Primary sores are not confined to the genital organs, as I have myself seen them on the eyelids, lips, palate, tonsils, ears, nipples, breast, anus, thighs, fingers; in fact, there is no part of the body but what may be the seat of a primary lesion, and this should, in my opinion, never be lost sight of.

It is, I feel sure, quite unnecessary to describe the appearance of the so-called *Hunterian* or *indurated sore*, but I will at once state that the sign common to all syphilitic sores is the presence of induration. This may appear to some contrary to the teaching of former years, but in my opinion a sore which is not followed by induration is not syphilitic.

With regard to the so-called *soft sore* I will at once state that the generally accepted opinion is that it is a purely contagious disease accompanied by a bubo, usually suppurating and in no way syphilitic. Let me ask you, then, to grant that induration is the only sign in the sore to be relied upon, and for a short time let us consider how this sign may be delayed or so diffused as not easily to be detected. If the inoculation occurs on any mucous membrane or dense fibrous structures, such as the glans penis or cervix uteri, you must expect the induration to be long in appearing. If, however, it occurs on the skin, the induration rapidly forms and the sore assumes early its typical aspect. I account for the delay in the appearance of the induration on mucous membranes by the early ulceration which invariably takes place. For until the structures beneath the mucous membrane are involved the induration does not appear, and on the glans penis and cervix uteri the induration is so diffuse that, until the sore has existed for a lengthened period, owing to the unyielding nature of the structures the induration is difficult to detect. I would impress upon you to bear in mind the fact that this induration is always accompanied with ulceration and loss of structure; hence, typical primary lesions in these situations present a punched-out appearance, the sore in the earliest stage being merely an abrasion, readily bleeding.

The chief practical question to be asked of all patients presenting themselves with a sore after a suspicious connexion is the *date* on which they first noticed any lesion. This will naturally differ with the habits of the individual, some being more cleanly and observant than others, and the longer the date of the appearance of the sore after the connexion the greater is the probability that it will be syphilitic. But you will ask, Is induration sufficient to determine the specific character of a sore? I would answer, No. For, without the so-called witnesses which in my opinion are invariably present, no definite answer should be given. What, then, are these witnesses which silently corroborate the evidence presented by the indurated sore? They are the glands, more especially those in its immediate neighbourhood, which on examination will be found enlarged, hard, nodular, freely movable, and in no way involving the structures surrounding them; they are, in fact, the seat of a true adenoid infiltration. These two symptoms—namely, the indurated sore and the glandular infiltration—occur at one and the same time; there is no appreciable interval in their appearance; they come together and march side by side. Here may be noticed a fact which seems peculiar and common to all syphilitic affections, whether of glands or of other structures—viz., that their tendency is to fibroid induration and contraction rather than to suppuration. Hence a suppurating bubo is rarely seen in connexion with a true syphilitic sore. The patient has been under the influence of the poison for some five or six weeks, and the virus which is entering his circulation gives rise to symptoms common to all blood poisons—such as headache, loss of appetite, rise of evening temperature, and general pains. Together with these is noticed symmetrical enlargement of the glands of the body generally, and more especially those of the neck, at the side of the ligamentum nuchæ, the bend of the elbow, and in the axilla.

The period of fever is intermediate between the primary and secondary stages, and is of somewhat indefinite duration. It appears to depend upon the rate at which the virus is entering, and upon the resistance inherent in the individual. When sufficient of the poison has accumulated, a general manifestation follows, and we have presented to us the so-called *secondary symptoms*. I will briefly run through them in the order commonly observed, but, in adopting the division usually mentioned in books, I would say that my experience leads me to the conclusion that there can be no arbitrary line drawn between secondary and tertiary stages, as they are frequently intimately dovetailed together; the common features to the secondary stage being that they are lesions confined to the skin and mucous membrane, the tertiary attacking the deeper structures.

It is not necessary for me to describe minutely the first roseola, but simply to state that, according to my own observation, it is usually discovered first in the region of the loins, subsequently appearing over the trunks and limbs. I wish next to draw your attention to the throat affection, which appears as a well-defined erythema over the soft palate, fauces, and tonsils, quickly followed by abrasion and ulceration. The ulceration assumes an ashy-grey appearance, leaving a stain, which I can only describe as similar to that left in the track of a snail. At a later stage the tonsil becomes flattened and enlarged, and the edge of the ulceration becomes raised and thickened, so that it presents a condylomatous appearance. Concurrently with this, the roseola becomes coppery, the skin desquamates, and the patches assume a condition resembling psoriasis. Should these patches occur in the folds of skin where there is warmth and moisture, such as about the arms, armpit, or umbilicus, they assume the typical sequela termed *condyloma*. This can be easily distinguished at any time from a wart by the following characteristics: it is broad at the base, but slightly raised, and the surface is smooth and moist, with a foul, thin, ichorous discharge. Condyloma is the most common of all the secondary lesions that I know of, and it is a curious fact that I have noticed persons who present large surfaces covered with this condition, frequently have little or none of the other sequelæ present. Owing also to their painless condition, they are the most common means by which the disease is communicated. Their distinctive characters are observed in whatever position they are situated.

Other variations of the secondary skin lesions appear to be modified by the individual idiosyncrasy of the patient. In those that are anæmic and broken down, either by sexual excess or spirit drinking, the eruption rapidly becomes pustular, so that the whole surface of the body may be studded with small vesicles, which on coalescing form crusts. These groups of eruption generally assume a crescentic shape, and are not limited to any one particular spot. The gouty and scrofulous diatheses appear to intensify and render more severe this condition, and it is to be noticed that when the vesicles or scabs fall off maculæ and stains form. Now this staining is extreme, and is one of the peculiar features common to all syphilitic eruptions. These various manifestations, unless arrested, rapidly pass into the so-called tertiary stages, which are represented by ulceration of the edges of the tongue, periosteal swellings, deposits in the testis, iritis, alopecia, and others with which you are all familiar. The one leading feature of the tertiary form is that it attacks bone and muscle—in fact, no structure being exempt; forming, for the most part, deposits or gummata in internal organs which tend to fibroid degeneration and contraction. In some situations, however—as, for instance, on the tongue, palate, or skin—nature seems to make an effort to discharge the virus, and they ulcerate rapidly, leaving a characteristic sore. Those that occur in bone appear to be an infiltration of the structure, which leads to disintegration and produces the so-called true ulceration of bone, presenting the black, worm-eaten appearance commonly seen.

The latest phases of the disease are met with in connexion with changes in the structure of nerves and arteries, being probably a frequent cause of paralysis, aneurysm, embolic

lesions, &c. All the above conditions may be observed to occur within a few months, or may be prolonged indefinitely.

Communicability.—Having described the disease so far, let me now mention that in my opinion all stages of it are communicable either by direct contact or by mediate communication—that is, by the intervention of some intermediary person or material. For instance, suppose I have examined a person with syphilis and handled the virus, and without taking the precaution of washing my fingers I proceed to examine another person who is healthy but has some breach of surface,—I may give him syphilis without having the disease myself. Again, the virus may be conveyed by tobacco, pipe, or drinking-cup.

We now pass to the consideration of another form of transmission, by which the disease is conveyed to the offspring. This may occur through either parent. The only point to be observed is that a woman can bear a syphilitic child without being herself infected. As you are aware, syphilitic poison frequently leads to abortion, or the child may be born at the full time and the symptoms may either be present at the birth or come on within a week or two. There is a further set of symptoms which appear about the age of puberty, some forms of which I hope to show in the wards.

I would mention my conviction that as the virus filters through a series of individuals it becomes attenuated and produces a milder chain of symptoms. Indeed, I incline to the opinion that it may eventually become so attenuated as to give rise to little more than a local lesion, followed with but faint constitutional signs. It is only in this manner that one can account for certain individuals having an immunity from the disease, when we know for a fact that they have been exposed to frequent infection and escaped, whilst others have contracted the disease. This is also shown where regiments in moving into fresh quarters bring with them a fresh type of virus. As a consequence we find that all the hospitals in the neighbourhood, and even the Lock Hospital with which I am connected, are filled with cases which exhibit severe types of the disease. After a time, which is variable, the disease resumes its normal standard until a fresh importation again occurs. With reference to this question of the change of type, it is by no means uncommon to find more than one typical hard sore in the individual at the same time. It must not be forgotten that syphilitic sores are liable to conditions which may be present in any non-specific wound. Hence, owing to extreme exhaustion in a patient, or to his mephitic surroundings, the initial inflammation may lead to death of the part and so produce phagedæna; or, again, the sore may be attacked by erysipelas or forms of cellulitis. Another point I would bring before your notice is that spots in which frequent attacks of syphilis have occurred seem peculiarly liable to become the seat of cancer, either because cancer and syphilis have an affinity for each other, or because the spot so irritated becomes the exciting point of the latent hereditary disease. I have frequently seen epithelioma of the tongue appear on old syphilitic lesions.

With regard to prognosis, I may state that one attack of syphilis generally renders the patient secure from further infection; although cases have been mentioned where it has been acquired twice and the patients have passed through a second course of symptoms. This, however, I have never seen myself. The questions which we are chiefly called upon to answer are the length of time it will take to effect a cure and the fitness for marriage. With regard to the former, I would state the probable time to be from one to two years, according to the nature of the case, age of individual, and his peculiar idiosyncrasy; and with regard to the fitness for marriage, if no symptoms have existed for a year, and no glandular enlargement or disease of testicles be found present, he may safely be permitted to marry.

Treatment.—Let us divide it into local and constitutional. For my own part, and it is the opinion of those connected with me at the Lock Hospital, the only remedy which has a specific and decided action upon the course of the disease is *mercury*. I know of no one at the present day who attempts to effectually treat syphilis without the use of that drug. And I would say, as mercury is the most powerful of all germicides, we could not rely upon a safer remedy with which to attack a poison which in all probability originates in bacilli. The efficacy of mercury was fully recognised by the older writers, but unfortunately they pushed the remedy beyond the required limits, and thus added a mercurial to the syphilitic poisoning.

First, with regard to local treatment. It has been proposed by some to remove the sore either by excision or destruction by caustic, or acids, together with removal of neighbouring glands. To my mind such a treatment is impracticable and must prove of no avail, so we may dismiss such a line of treatment from our consideration. *Cleanliness* is the first point to be insisted upon. Strange as it may seem, in practice this is even a difficulty. Should the sore be situated on the external portions of the male organ nothing is better, or more comfortable and cleanly, than the application of a small portion of the emplastrum hydrargyri (B.P.), spread on wash-leather, warmed and cut to the size of the sore; it also has a protective action. But in either sex, when the sore is found in moist situations, nothing answers better than dusting them with calomel or oxide of zinc in equal proportions. Especially in condylomata do we see this by its rapidly causing them to dry up and disappear. Oxide of zinc is better than starch, as it does not decompose. Attention should also be directed, especially in the female, to keeping the parts as dry as possible by frequent changes of linen, or by the use of the sanitary bandage. Should the sores be painful, the application of a 15 per cent. solution of cocaine at once gives relief. Under all circumstances, lotions, ointments, poultices, and fomentations are, in my opinion, better avoided. The use of a warm hip-bath night and morning will add considerably to the patient's comfort, but special directions must be given as to drying the parts thoroughly afterwards.

Constitutional treatment may be divided into general and specific. The general treatment consists in attention to ordinary hygienic principles—such as plenty of fresh air, warm clothing, moderate exercise, the avoidance of all chills or rapid changes of temperature. Diet should be light and nutritious, but mainly nitrogenous. With regard to stimulants, they should be avoided, for alcohol in any form adds largely to the activity of the syphilitic virus. So deeply impressed am I with this that it is a common expression of mine to all patients that, "if they want to keep their syphilis, they have only to drink sufficient alcohol and they can keep it as long as they please." In fact, to my mind no treatment of syphilis is of any avail to the drunkard. In all cases in which I have seen fatal or disastrous results alcohol has been at the root of the mischief. Special directions must be given as to the necessity of keeping early hours during the whole course of the disease, as the nervous system is so liable to be attacked at any time. The specific treatment of syphilis by mercury can be carried out by administration through the alimentary canal or the skin, or directly injected into the tissues of the body. When administered through the alimentary canal, it is best given in the form of two grains of mercury pill and a quarter of a grain of opium night or morning, or one grain of hydrarg. c. creta with one grain of quiniæ sulph. or two grains of ferrum redact., three times a day. Some prefer the green iodide of mercury given in the form of a pill, others a mixture composed of liq. hydrarg. perchlor. and iodide of potassium. Against these, however, I have a distinct objection, as they are liable to rapid decomposition, producing purging and irritation or rapid salivation. When administered through the skin it can be done, as you are aware, by the inunction of ung. hydrarg. fort., or by the oleate of mercury, or by the use of the calomel bath. The only practical point to be observed in the inunction is that it be not too frequently applied to one spot, otherwise it produces irritation. Against all the above methods it may be stated that a considerable time is occupied before any effect of the drug is noticed, as their action is most uncertain, and in addition sudden salivation may ensue. I would mention that by these methods we have no power of saying what amount of mercury is absorbed at any time during the course of the disease, and to my mind it is a very crude and imperfect manner of administering such a powerful poison as mercury. Have we, then, discovered a better plan? Yes. By administering mercury directly into the tissues of the body I believe we have done so. Several preparations have been suggested for this purpose, and until recently I obtained the best results with an intra-muscular injection of a solution of perchloride of mercury (eight grains to one ounce of distilled water). I injected twenty drops of this solution once a week into the gluteal region, with remarkably good results. Out of 1924 injections, there has been only *one* case of abscess, and that resulted from the injection being improperly performed, as the fluid was injected into the subcutaneous tissue. Even in this

case the local irritation was slight, and it gave rise to no other symptoms. The patient was injected twenty-six times afterwards, with no ill effects. Two points are to be observed with the use of the solution: first, that the pain at the time is sometimes severe and may continue for two or three days; and, secondly, if bleeding takes place at the seat of puncture, or in those of a hæmorrhagic tendency, indurated nodules form, which remain for two or three weeks. Satisfactory as were the results obtained by the solution of perchloride of mercury, I have more recently obtained even better results with a solution of sal alembroth—a double chloride of mercury and ammonium. It is made by dissolving thirty-two grains of mercuric chloride and sixteen grains of pure chloride of ammonium in distilled water sufficient to yield two fluid ounces of product. Ten minims of this solution will equal one-third of a grain of mercuric chloride. It is an absolutely permanent solution, not liable to fungoid growth or other decomposition, and without precipitation. So far I have given over 600 injections with this solution, using ten minims for a dose, and no untoward effect has been observed; the pain is comparatively slight, the slightest induration following, and the effect most satisfactory, as, after two injections equalling two-thirds of a grain of mercuric chloride, the physiological action of the drug was produced and could be maintained by an injection once a week, whilst the symptoms of the disease, both local and constitutional, underwent most rapid and favourable change. Whilst prosecuting my experiments in relation to the injection of mercury, at the request of my *confrères* on the Continent I tried calomel and glycerine, and also calomel with pure petroleum, according to their directions. In both cases the results were most unsatisfactory, as abscesses formed, accompanied with great pain and irritation. It is right to remark that in both instances, although the amount of calomel injected was about one grain and a half, decided mercurialism followed. Since I commenced injection in 1884 I have been accustomed to inject one-third of a grain of perchloride of mercury, or the equivalent of sal alembroth, once a week. I have found after doing so all primary lesions healed, and for the most part signs of mercurialism have been present. I have then injected once a fortnight until all glandular, throat, and other sequelæ have disappeared; this has generally occupied another eight or ten weeks. Then the injections have been continued on an average of once a month, some tonic being given in the meantime. Occasionally towards the end of the treatment a few doses of the iodide of potassium have been given, and the patients have been kept under a mild but continuous course of mercury, on an average from eighteen to twenty-three months. The average quantity of mercury injected has been from six to eight grains during the whole course of the treatment. I do not believe that iodide of potassium has any curative effect on syphilis. I look upon it only as a whitewash. It is useful, however, in profuse suppuration and old tertiary conditions. Yet unless the patient is subsequently placed under the influence of mercury the symptoms will invariably recur. Here I may remark that I have frequently observed, on strict examination in severe cases of nerve lesion occurring at a late period of the disease, that the primary condition has been followed with but slight sequelæ, and the patient has received but a slight course of mercurial treatment.

I can only briefly refer to the treatment I adopt in hereditary cases. I find the inunction of the mercurial ointment, steadily continued, is the most reliable in early cases, bearing in mind the important fact that it is almost impossible to salivate a child.

NEW BELGIAN MEDICAL ASSOCIATION.—A new local medical *cercle*, or association, has just been formed in West Flanders, with Courtrai as its headquarters. M. Craene was elected President and M. Mahieu Secretary. At the inaugural ceremony the Mayor pointed out what Courtrai had already done in the way of public hygiene, and enumerated some matters which have still to be looked to. Dr. Kuborn gave a scheme for the future work of the Society, including inquiries into epidemics and other causes of death, meteorological influences, &c. It was also intimated that the new society might find some useful employment in the examination of the various specimens of drinking water used in different localities. Of course a banquet came as a suitable termination to the inaugural proceedings.

OSTEO-PLASTIC RESECTION OF THE FOOT BY THE METHOD OF MIKULICZ.[1]

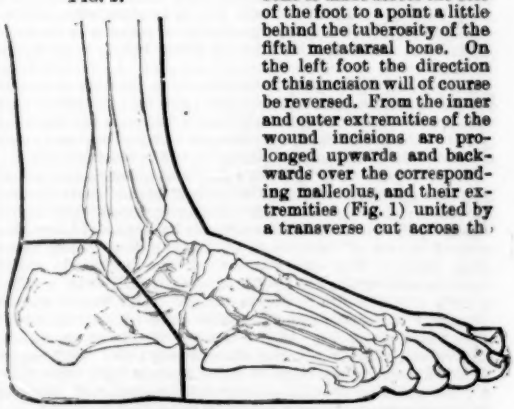
BY SIR WILLIAM MAC CORMAC.

THE lad whose case I wish to bring before the Society this evening is now sixteen years old. On March 12th, 1887 I performed the operation introduced by Mikulicz of Prague and Wladimiroff of Kasan. So far as I know, it has not been previously performed in England, and as now more than a year has elapsed since the date of the operation the Fellows of the Society will be able to estimate the amount of usefulness attained by the limb. I would wish, therefore, to invite the opinions of my surgical colleagues upon the value of the operation in suitable cases. The following notes were taken by Mr. C. H. James, dresser of the case.

W. B——, aged about fifteen, a clerk, much emaciated, with a pasty face and a dull suffering expression, was admitted to St. Thomas's Hospital on January 29th, 1887. There is no history of phthisis, and both parents are alive and well. Six months before, the boy fell downstairs and sprained his left ankle. He was treated as an out-patient with strapping and plaster-of-Paris splints without improvement. One abscess had formed behind the inner malleolus, which was opened, and another in the sole of the foot. Swelling was very prominent on each side of the tendo Achillis. The sinuses led down to diseased bone, and it was evident the joint between the astragalus and os calcis was extensively diseased. The parents would not at this time consent to any operation, so the sinuses were laid open, the granulation tissue scraped away, and drainage tubes inserted. But the general condition of the patient became much worse, and there was now evidence that disease was beginning in the ankle joint. The parents very reluctantly consented to an operation, stipulating, however, that the foot must not be amputated. The soft parts covering the heel were much infiltrated and riddled with sinuses; but considering the disease to be limited to the os calcis and astragalus and involving secondarily the joints adjacent, Sir William decided to perform the following operation.

The patient was placed in the prone position. If it be the right foot, the knife is introduced on the inner border of the foot just in front of the scaphoid tubercle, and a transverse incision extending to the bone is made across the sole of the foot to a point a little behind the tuberosity of the fifth metatarsal bone. On the left foot the direction of this incision will of course be reversed. From the inner and outer extremities of the wound incisions are prolonged upwards and backwards over the corresponding malleolus, and their extremities (Fig. 1) united by a transverse cut across th

FIG. 1.



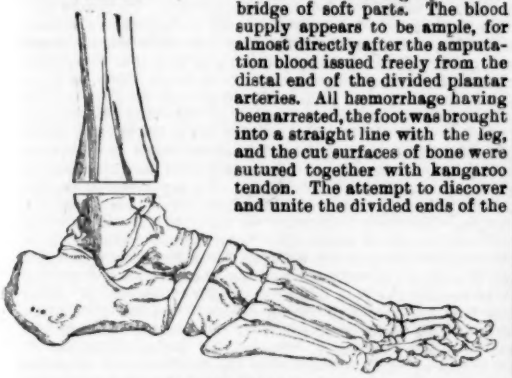
Position of the incision in the soft parts.

back of the leg made down to the bone at the level at which it is to be sawn, usually immediately above the joint surface of the tibia. In cases where a larger removal of the tibia and fibula is required, the lateral incisions must be more oblique and the posterior transverse cut made at a higher level. The ankle joint is now opened from behind, the disarticulation completed, and after flexing the foot the soft parts are carefully separated in front until the medio-tarsal joint is reached, at which disarticulation is effected as in Chopart's operation. The heel portion of the foot, consisting

[1] Read before the Medical Society of London on April 30th.

of the astragalus, calcis, and the soft parts covering them, is thus removed. The articular surfaces of the tibia and fibula with the malleoli are now sawn off, as well as those of the cuboid and scaphoid bones. (Fig. 2.) The anterior portion of the foot remains connected with the leg by a loose bridge of soft parts. The blood supply appears to be ample, for almost directly after the amputation blood issued freely from the distal end of the divided plantar arteries. All hæmorrhage having been arrested, the foot was brought into a straight line with the leg, and the cut surfaces of bone were sutured together with kangaroo tendon. The attempt to discover and unite the divided ends of the

FIG. 2.

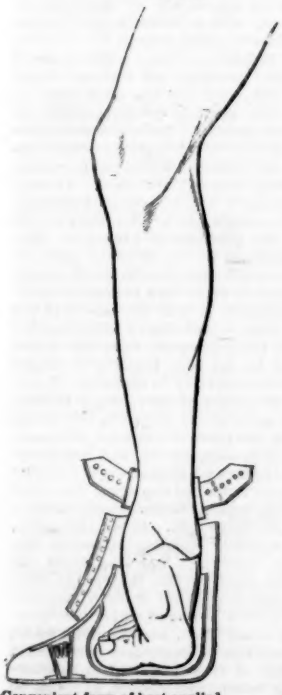


Line of section of the bones.

posterior tibial nerve failed on account of the sodden condition of the soft parts. Suitable dressings and a plaster-of-Paris splint were applied, the toes being brought into a position of complete dorsal flexion.

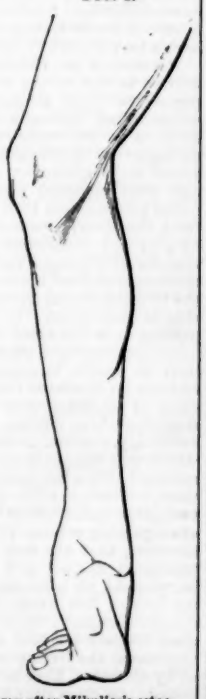
I need not detail the after-treatment; the boy made an excellent recovery, and a firm bony union eventually took

FIG. 3.



Convenient form of boot applied to the stump.

FIG. 4.



Stump after Mikulicz's osteoplastic resection.

place. Sensibility began to return in the sole of the foot in about a month, and this gradually became more complete. In December the boy returned to the hospital to be fitted for the boot he now wears. (Fig. 3.) He can stand or walk with ease and comfort. The left limb is half an inch longer than the right. (Fig. 4.) The sensibility of the left foot appears to be perfect, showing that the divided nerve ends have become united. The toes are mobile. I regard such a result as this, obtained under very unfavourable circumstances, an exceedingly satisfactory proof of the utility of the operation. Wladimiroff of Kasan, in 1872, appears to have been the first to perform the operation; but Mikulicz first published an account of it in Langenbeck's *Archiv*, 1881. The functional result, as I think this case will show, is an admirable one. An artificial pes equinus is procured, the object being to preserve the toes and metatarsal bones, which are sacrificed in other amputations of the foot. These are brought into a straight line with the leg, and the toes bent at a right angle, so that the patient walks on the ends of the metatarsal bones covered by the thick pads of tissue which invest them; a broader surface of support is provided than is afforded after either Syme's or Pirogoff's amputations, and there is some elasticity of foot left. (Fig. 4.) In ordinary cases the limb will be longer by nearly an inch, which can be readily compensated for by a thicker sole to the other boot. As regards indications, it may be at once conceded that the operation will prove better adapted to cases of injury, gunshot injury more especially, than for those of disease. My experience of this case, however, would tempt me to adopt the procedure again in any case where the bones of the heel and the soft parts covering them were extensively damaged or diseased, the anterior half of the foot remaining healthy.

[The patient was exhibited to the Fellows. He walked up and down the room, both with and without his boot, with great ease and evident satisfaction to himself. The union is quite solid, and he now attends to his daily work without any inconvenience.]

CLINICAL EXPERIENCE OF SOME OF THE MORE RECENTLY INTRODUCED DRUGS.

BY THOMAS OLIVER, M.D., M.R.C.P. LOND.,
PHYSICIAN TO THE ROYAL INFIRMARY, AND LECTURER ON PHYSIOLOGY IN THE UNIVERSITY OF DURHAM COLLEGE OF MEDICINE, NEWCASTLE-UPON-TYNE.

I VENTURE briefly to place before the profession the results of my experience of some of the newer drugs. We cannot but admit that within the last few years very important additions have been made to our already long list of therapeutic agents, and that, whilst many of them have quite fulfilled all that was expected of them, others have just as much failed to do so, and as a consequence are being discarded.

Jambul was recommended a few months ago as a cure for diabetes mellitus. The powdered seed was credited with having the property of diminishing the secretion of urine and of arresting the formation of sugar. Four patients suffering from diabetes have been treated by me with powdered jambul. I began with five-grain doses thrice daily, and gradually increased the dose to fifteen grains. Two of the patients died, both from coma; the other two are still alive, but are no longer taking the drug. It cannot be said that any one of them received the slightest benefit. The daily amount of sugar passed out of the system was not diminished, thirst was not in any way abated, the daily discharge of urine remained as before, and the weight of the body was not increased. In one of the cases, strange to say, two days after taking the jambul the daily elimination of sugar fell from 4000 to 600 grains, but on the following and succeeding days the amount rose, and by degrees increased until it reached the sum eliminated before the drug was administered. Arterial tension was not in any way affected by the drug.

Salol, a compound of salicylic and carbolic acids, has been recommended as an antifebrile agent. In my hands it has not had any effect in reducing the high temperature of phthisis; nor did it, as one would have expected from the nature of the ingredients of which it is composed, diminish the amount of pus secreted by inflamed surfaces, as occurs in pyelitis and cystitis. In these latter ailments the drug was not at all well borne. I have seen discolouration of the urine produced by it, but I have never met with any bad effects, as in carbolic acid poisoning. It is as an antirheumatic, however, that salol has also been recommended, and my experience of it in cases of rheumatic fever is ex-

tremely favourable. Where the temperature in such has been high, and has not been reduced for more than a day or two by sodium salicylate in fifteen-grain doses given every few hours, and where, owing to the anæmia which had been developed and the great depression caused by the sodium salt—symptoms which forbade an extended use of the drug,—salol has with me not only been followed by a reduction of temperature and pulse, both of which have ever afterwards remained at the normal, but by a feeling of comfort and a sense of well-being such as patients experience when, having passed through a serious illness, they are conscious of having become convalescent. Salol has not perceptibly diminished the tendency to endocarditis in rheumatic fever.

For the earliest notice of *Collinsonia Canadensis*—stone or knob root—we are indebted to Dr. Shoemaker of Philadelphia. Like nearly all the new drugs, it is recommended, but not by him, for nearly every disease—for more, at any rate, than it can ever be expected to accomplish; but so far as its curative effects upon the genito-urinary passages are concerned, I can speak of it in the highest terms. It is spoken of as a sedative and an antispasmodic, as relaxing the spasm of the ureters, and therefore allowing of the escape of renal calculi with greater ease and less pain. It is also recommended as a remedy in acute cystitis. A few months ago Dr. Anderson of Loftus-in-Clevedale sent me a boy, aged twelve, who for some time previously had been the subject of excessively frequent micturition, passing large quantities of pus (sometimes with, sometimes without blood) in the urine, and who had complained much of suprapubic pain, increased by pressure, and also pain at the point of the penis. He was an intelligent lad, and could tell to the week when his illness began, the first symptom being increased frequency of micturition. When admitted, his urine was alkaline, had a most disagreeable odour, and, on standing, the pus was seen to reach half-way up the glass. As his symptoms pointed to the presence of stone in the bladder, he was sounded by Dr. Anderson, but no calculus was detected. Shortly after this—his condition meanwhile becoming worse—he was sent to Newcastle. For a week or ten days he was treated by the ordinary remedies hitherto employed in the treatment of cystitis, suppositories of belladonna, too, being employed night and morning, but without the least improvement. Thinking that there might be a stone in his bladder, I had the patient chloroformed and examined for stone by my surgical colleagues, Dr. Hume and Mr. Dodd. No stone was found. Again for a fortnight the ordinary remedies were employed, but as the boy's condition was gradually becoming worse I put him upon the liquid extract of collinsonia in fifteen-minim doses thrice daily. Within ten days he felt much more comfortable; he could now retain his urine longer, and in this way his night's rest was not so much broken. By degrees the height to which the pus reached in the glass was seen to be getting less. The pus, and with it the albumen, gradually diminished, until within twenty-one days from taking the collinsonia all the pus had disappeared and the patient could go from four to six hours without requiring to empty his bladder. His night's rest was now no longer disturbed, his pains had all gone, the urine had again become clear, appetite had improved, flesh had been put on, and in this condition he went home. In a letter from Dr. Anderson, received a few days ago, I am told that several weeks afterwards the patient had a slight return of his symptoms, but they disappeared on again resorting to the collinsonia. Now here was a case which baffled treatment by all the drugs generally used in the treatment of cystitis, so that we cannot but regard the good and speedy result obtained as due to the collinsonia. In another case, that of a lad sent to me by Dr. Mackay of Esh, in whom there was pyelitis due to injury, and in whom every week or ten days the ureter evidently became blocked judging from the suppression of urine, with extreme pain and fulness in the region of the left kidney, and rigors, the pain greatly disappeared after taking collinsonia, and the urine was frequently clear of pus, and only once in eight weeks had the ureter become blocked; the symptoms, but without the rigors, have from time to time recurred. In other two cases of pyelitis I have tried collinsonia; but beyond making one of the patients feel a little more comfortable, it cannot be said that the amount of pus has diminished. The best results are obtained in the treatment of cystitis.

Antipyrin is certainly a drug which has a wonderful power in reducing high temperatures, and that quickly too. In some cases of typhoid fever I have known it reduce the temperature within two hours from 106° to 101°. It is in the treatment of typhoid fever that its best results as a heat-reducing agent have been obtained. Here a high temperature may become a source of danger; in patients thus affected tissue metabolism is exaggerated, and, as the functions of the various excretory organs are deranged, the increased amount of waste material accumulates in the blood and tends further to endanger life. To reduce the high temperature in such is surely an object we should strive for, so long as that reduction is neither too hasty nor too great. It is these very things, in fact, that have been claimed for the cold-bath treatment of fever. Now, in antipyrin, carefully and judiciously employed, we have a drug which gives the same result without removing the patient from his bed. It is recommended by some writers to be given in doses varying from fifteen to thirty grains every few hours. Here a word of caution must be expressed, to young practitioners particularly. To my knowledge, the pushing of antipyrin in fifteen-grain doses is not without danger. The drug requires to be watched, for not only has the temperature in some cases been rapidly reduced below the normal, but in some collapse has taken place—collapse not of a slight, but of a threatening, character, and requiring to be met by the free administration of stimulants. After the first two doses of fifteen grains, I seldom give it in larger doses than from seven to ten grains, when it has to be taken regularly. Since the recommendation of antipyrin by M. Germain Sée in the treatment of migraine and neuralgia, and in the treatment of the ill-defined and so-called ovarian pains in women in whom no special pelvic or uterine disease can be detected, antipyrin has in my hands proved itself to be a most useful and serviceable drug. In a case of chorea, too, with mitral stenosis—a young lady of eighteen,—and where arsenic, chloral, bromide, and other medicines failed, antipyrin, given in seven-grain doses thrice daily, has been followed by disappearance of the disorderly movements, and in a case of locomotor ataxy the burning pains in the soles of the feet subsided under its administration. I have had no experience of antipyrin as a hæmostatic in typhoid fever. Given for neuralgia, I have seen a herpetic eruption follow the second dose.

Ammonium or Calcium Sulphide.—Some months ago I noticed in one of the medical journals the results of experiments upon animals subjected to the influence of sulphuretted hydrogen in the manner recommended by Bergeon in the treatment of phthisis. Into the rectum—as suggested by Bergeon for phthisical patients—were injected large quantities of sulphuretted hydrogen in water, and after repeated injections the rabbits died. It was found post mortem that glycogen had disappeared entirely from the liver; repeated washings out of the liver failed to give any indication of the presence of glycogen. The absence of glycogen post mortem in the liver of animals thus experimented upon was so constant that to the observers the two circumstances seemed to stand in a causal relationship to each other. If, therefore, it was the case that the passing into the blood of large quantities of sulphuretted hydrogen destroyed entirely the glycogenic function of the liver in health, it occurred to me that possibly it might restrain its increased functional activity in diabetes. Three cases of diabetes were accordingly treated, each patient receiving three minims of ammonium sulphide, this being extremely volatile. In one of the cases of diabetes, albumen, which was present in the urine, disappeared, and has never returned. For a few weeks the daily amount of sugar fell one-third, but the quantity of urine remained the same. The other two patients felt better whilst taking the drug—one of them even gaining several pounds in weight. It is to be noted, however, that the special diabetic diet begun before the treatment was adopted was continued, and this could not be without an influence for good. After taking the drug for four or five weeks, it was found that in each case the digestive organs gradually became deranged, and a most complete distaste for food was established, accompanied by an increase in the feeling of lassitude so frequently complained of by diabetics, that this line of treatment had to be abandoned. Calcium sulphide is being tried instead, as it can be taken for a longer period without giving rise to intestinal disturbance.

Hydrastis Canadensis, or the Golden Seal, is, of all the more recently introduced drugs, one which, with a larger experience, increases in favour daily. It was the knowledge which Professor Schatz of Rostock had of the efficacy of hydrastis canadensis in inducing strong peristaltic contractions of the intestine that led him to employ it as a

uterine tonic. So successful has Schatz been in the treatment of diseases of the uterus and its appendages which are attended by considerable losses of blood, that since employing this drug in the treatment of these cases there has not been in his district, it is said, the necessity to have recourse to surgical proceedings so frequently as formerly. Hydrastis is recommended for all forms of chronic metritis, for inflammations invading the tissues around and in the wall of the uterus, for ovaritis, and for uterine fibromata, the growth of the latter, it is maintained, being not only arrested, but in many cases they have been found to undergo retrogression. Hydrastis certainly does restrain the flow of blood in myofibromata, but it is in cases of menorrhagia where the loss of blood depends upon a para- or perimetritis that its efficacy, in my opinion, is most marked. It not only relieves ovarian pain, but it has checked uterine hæmorrhage in cases where there has been such evidence of inflammation outside and immediately around the uterus that intra-uterine medication could not have been attempted. The drug has, in my hands, had little or no effect upon uterine hæmorrhage dependent upon mucous polypi. I regard hydrastis canadensis as a most useful and valuable addition to our already large list of uterine remedies. It soothes ovarian pain, acute or chronic, and checks the bleedings of the latter; it checks the bleeding of endometritis, and relieves that unpleasant pain which prevents the woman thus affected from either sitting or walking; it relieves, and in many cases has arrested, the hæmorrhage due to puerperal metritis and chronic peritonitis; and in many instances it has relieved the headache so frequently complained of by women who are the subjects of chronic inflammatory affections in and around the uterus and ovaries.

Salix Nigra, or the Pussy Willow, is reported upon by Mr. Pain in the Transactions of the Texas State Medical Association as a successful agent in the treatment of ovarian hyperæsthesia, uterine neuralgia, and spermatorrhœa. He regards it as a sexual sedative, similar to bromide, but without its depressing effects. Dr. Hutchison of Glasgow speaks well of the drug, and Mr. Hurry Fenwick found it of much service in the treatment of gonorrhœa and gleet. In my hands it has not been of any value in the treatment of spermatorrhœa, but in the treatment of ovarian pain due to pelvic peritonitis, or an associated metritis, or in the chronic ovarialgia of gonorrhœal infection, relief has followed its administration in some, whilst in others the ovarian pain has completely disappeared. In cases of pelvic peritonitis, where there has been ovarian pain and uterine hæmorrhage, the combination of hydrastis canadensis and salix nigra has been of such signal service that I cannot press too hard upon the members of our profession when I ask them to give it a trial. In the highly nervous condition into which some women are so frequently thrown soon after the climacteric period—in short, hyperæsthesia rather than anæsthesia, excitability rather than atony, of the nervous system is present—salix nigra and hydrastis canadensis have answered well in combination.

THE MUD-BATHS OF MARIENBAD.

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THE mud-baths (*Moorbaeder*) of Marienbad are much less known than the saline-alkaline waters, especially the Kreuzbrunnen, to which Marienbad owes its celebrity; but they are the most important baths in Bohemia. In the neighbourhood of Marienbad are found two kinds of earth (*Mineralmoor*), which are applied to medical purposes; the "old mud" and the "new mud." The mud consists of decomposed mineral and vegetable substances, of residues of plants, vegetable earth and ulmic acid, of resins, siliceous earth and clay, of phosphate, of protoxide of iron, sulphate of iron, chloride of sodium, sulphates of carbonic acid, and sulphuric and formic acid. Springs of mineral water, and such as give out carbonic acid and sulphuretted hydrogen gas, rise from the bog in great numbers, and have without doubt contributed much to the peculiar decomposition of the plants. The "new mud," which is the stronger of the two earths, fresh from the bog, is of a brown colour, and shows incrustations and lumps of sulphuret of iron; when exposed to the air it rapidly turns black, and if kept dry forms a white crystalline powder on its surface. Exposed to the influence of the air and water, most of its constituents are oxidised, and the most essential result of this process consists in the formation, out of insoluble mineral and organic matter, of substances capable of solution and of certain volatile acids. The bisulphuret of iron is changed more or less completely into soluble sulphate of protoxide of iron. The new Marienbad mud considerably exceeds all the muds hitherto analysed, including that of Franzensbad, in the amount of iron contained.

The physiological effects noticed when one enters a mud-bath are, according to experiments both on myself and my patients, as follows: 1. A sensation of excitement; warmth through the whole body, especially in the face; oppression in breathing; and palpitation of heart in those not accustomed to mud-baths, which symptoms cease after about ten minutes, leaving merely a red face and a feeling of heat at the vertex of the head; from the buttock and scrotum a vivid burning sensation extends up the extremities and back, with more or less tickling in various places. 2. The first effect upon the pulse is an increase of from 10 to 12 beats per minute (in a novice of 16 per minute). During the remainder of the bath, it is true, this rate diminishes, but always remains from 4 to 8 beats higher than usual; two hours after the bath it is again regular. The number of respirations is also raised generally from 2 to 6; in the beginning still higher, but half an hour afterwards they become normal again. The more consistent the mud is, the clearer these effects. 3. The bodily heat, measured in the armpit, increased during a bath of half an hour by from 1·5° to 3·5° C. On bathing days the temperature of the body in the morning and evening has been greater by from 0·5° to 1·3° C. than usual. 4. The perspiration was more active immediately after the bath. The diuresis did not appear promoted after every mud-bath. The urates excreted in the urine were augmented by the mud-bath; the phosphates, however, diminished. 5. The congestion of the head and the hyperæmia produced in very plethoric persons, as well as attacks of fainting or bleeding from the nose, are consequences of disturbance in the nerves and circulation, and the discharge appeared greatly increased when the baths were taken on the approach of menstruation.

On account of their general and special stimulating and animating effect on the skin these baths are used with benefit in the following affections:—1. Neurosis dependent upon anæmia or sexual derangements of women or upon spinal irritation; and in neuralgia of one or more nerves and their branches when free from inflammation. 2. Paralysis of rheumatic and arthritic origin, especially if caused by exudation on the periphery of the nerves, where it is intended to promote resorption and to restore interrupted innervation, as in anæmic women after difficult confinement; puerperal diseases, especially when an exudat remained in the pelvis; in hysteric paralysis and that caused by cold in the lower extremities, or after sudden suppression of the catamenia in weak persons. All pressure on the nerves from rheumatic and gouty deposits is relieved by the mud-baths. In paralysis from apoplexy they also appear useful, but great precaution is necessary in cases inclined to congestion. 3. Chronic rheumatism of the muscles and joints when increased action of the skin is required. 4. Gout, because the mud-baths produce absorption of all swellings and local deposits around and within the joints, so that contractions and pseudo-ankylosis disappear, and there is increased change of matter, which promotes healthy nutrition. 5. Sexual derangements of females, when accompanied by anæmia or chlorosis, as in chronic metritis, dysmenorrhœa, amenorrhœa, hysteralgia, and chronic catarrh of the vaginal and uterine mucous membranes. 6. Pollutions, spermatorrhœa, and impotence, in consequence of loss of blood and flesh from exhausting diseases; extreme mental and bodily fatigue, as long as there are no organic alterations within the spinal marrow. 7. Abdominal complaints caused by abdominal obstruction, piles, and, moreover, by very frequent and debilitating hæmorrhages from piles, by swelling of the liver, in consequence of hyperæmia and infiltration of the lymphatic glands in scrofulosis. 8. Chronic enlargement of the spleen after malarial infection. 9. Inflammatory deposits in the peritoneal cavity following an attack of perityphlitis, parametritis, and perimetritis. The mud-baths are in all these cases attended with splendid results.

REMARKS ON

OGSTON'S OPERATION FOR GENU VALGUM;

WITH AN ANALYSIS OF SIXTY-FOUR OPERATIONS.

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IN the *Edinburgh Medical Journal* of March, 1877, Prof. Ogston described an operation for the relief of genu valgum which is worthy of study. I will state, in his own words, what that operation is:—

"The following operation was decided upon and put into practice on May 17th, 1876, on the left knee. The patient was chloroformed, the knee flexed as far as possible, and the thigh turned outwards. A long and strong tenotomy knife was introduced through the skin, three inches and a half above the tip of the internal condyle on the inner side gradually backwards in the groove between the condyles. As soon as it was estimated that the condyle was almost entirely separated, and that the saw had arrived near the popliteal space, the saw was withdrawn. The knee was completely extended, and then, with the hands, and the operator's knee as a fulcrum, the patient's knee was forcibly straightened by bending the legs inwards. The remaining connexions of the condyle with the femur gave way with a crack on the application of very moderate force, and instantly the leg became as straight as a healthy limb, and could even be put into a somewhat bandy (genu varum) position. The whole of the operation was conducted under carbolic spray, with a minute observance of Lister's antiseptic precautions, and the limb was put up in antiseptic dressings. It was then simply bandaged to a Liston's long splint, as in the drawing, the thigh and leg being kept in the same line by pads, and the boy was placed upon a hard mattress."

On June 6th, 1876, the right knee was similarly treated. On July 21st the boy (aged eighteen) left the Aberdeen Infirmary quite well, and walking perfectly. Four lithographs accompany the manuscript, illustrating Ogston's method of operating and its result.

On May 30th, 1871 (much against the advice of my colleagues at Westminster), I operated on a severe case of genu valgum by direct incision and removal of the exaggerated inner condyle.[1] The boy recovered with a most useful limb, after eleven weeks, a very marked time discrepancy existing between his case and those which follow. The accompanying table gives an epitome of my cases, forty-two in all, representing sixty-four knee-joints consecutively operated on at Westminster. Of these cases, nineteen are boys and twenty-five are girls. My oldest patient is of the age of thirty, and the youngest aged two years. The greatest width of deformity is twenty-two inches intermalleolar divergence, the generality presenting from twelve

TABLE OF MR. RICHARD DAVY'S CASES OF GENU VALGUM (OGSTON'S OPERATION).

No.	Sex.	Age.	Date of admission.	Date of operation.	Disease.	Date of discharge.	Result.	Single or double.
1	Female	15	Dec. 6, 1878	Dec. 17, 1878	Genu valgum.	Jan. 9, 1879	Recovery	Double.
2	Male	5	March 1, 1879	March 4, 1879	Genu valga.	May 12, ,,	Ditto	Double.
3	Female	14	May 16, ,,	May 20, ,,	Genu valga.	July 11, ,,	Ditto	Double.
4	,,	5	June 7, ,,	June 10, ,,	Genu valga.*	July 7, ,,	Ditto	Double.
5	Male	5	July 24, ,,	July 30, ,,	Genu valgum; synovitis; blow.	Sept. 6, ,,	Ditto	Single (right).
6	,,	15	Jan. 19, 1880	Jan. 20, 1880	Genu valga.	March 23, 1880	Ditto	Double.
7	Female	11	Jan. 14, ,,	Jan. 27, ,,	Genu valgum; synovitis from birth.	March 22, ,,	Ditto	Single (right).
8	,,	5	May 24, ,,	May 25, ,,	Genu valga.	July 30, ,,	Ditto	Double.
9	,,	8	May 25, ,,	June 1, ,,	Genu valga.	June 30, ,,	Ditto	Double.
10	,,	8	July 28, ,,	Aug. 10, ,,	Genu valga.	Sept. 15, ,,	Ditto	Double.
11	,,	13	Jan. 12, 1881	Jan. 18, 1881	Genu valga.	March 23, 1881	Ditto	Double.
12	,,	5	April 22, ,,	May 24, ,,	Left valgum.	June 17, ,,	Ditto	Single (left).
13	,,	17	Oct. 31, ,,	Nov. 1, ,,	Right valgum.	Dec. 18, ,,	Ditto	Single (right).
14	,,	8	Nov. 14, ,,	Nov. 21, ,,	Genu valga.	Dec. 12, ,,	Ditto	Double.
15	Male	9	Nov. 27, ,,	Nov. 29, ,,	Right valgum.	Dec. 20, ,,	Ditto†	Single (right).
16	,,	4½	Dec. 20, ,,	Dec. 20, ,,	Right valgum.	Jan. 14, 1882	Ditto	Single (right).
17	,,	6	Feb. 17, 1882	Feb. 21, 1882	Left valgum.	March 21, ,,	Ditto	Single (left).
18	,,	30	May 26, ,,	May 30, ,,	Right valgum; left varum.	Aug. 16, ,,	Ditto	Single (right).
19	Female	9	June 17, ,,	June 29, ,,	Genu valga, three years' duration.	July 25, ,,	Ditto	Double.
20	,,	13	March 2, 1883	March 6, 1883	Genu valgum (right).	April 23, 1883	Ditto	Single (right).
21	,,	3	May 18, ,,	May 22, ,,	Genu valgum (left).	July 3, ,,	Ditto	Single (left).
22	,,	4	May 25, ,,	May 29, ,,	Genu valgum (left).	July 13, ,,	Ditto	Single (left).
23	Male	15	May 22, ,,	May 29, ,,	Genu valga.	July 19, ,,	Ditto	Double.
24	,,	4	June 1, ,,	June 5, ,,	Genu valga.	July 9, ,,	Ditto	Double.
25	Female	8¼	June 27, ,,	July 3, ,,	Genu valga.	Aug. 12, ,,	Ditto	Double.
26	,,	16	July 14, ,,	July 16, ,,	Genu valga; 22 inch malleolar divergence.	Sept. 6, ,,	Ditto	Double.
27	Male	6	July 23, ,,	July 26, ,,	Genu valgum (right).	Aug. 20, ,,	Ditto	Single (right).
28	,,	16	May 16, 1884	May 20, 1884	Genu valgum (right).	Oct. 7, 1884	Ditto‡	Single (right).
29	Female	12	Aug. 9, ,,	Aug. 13, ,,	Genu valga.	Oct. 10, ,,	Ditto	Double.
30	,,	5	March 14, 1885	March 17, 1885	Genu valgum (right).	April 19, 1885	Ditto	Single (right).
31	,,	5	March 12, ,,	March 24, ,,	Genu valga.	April 27, ,,	Ditto	Double.
32	Male	3	July 25, ,,	July 29, ,,	Genu valgum (right).	Sept. 14, ,,	Ditto	Single (right).
33	,,	16	May 9, ,,	May 12, ,,	Genu valga.	July 15, ,,	Ditto	Double.
34	,,	3	July 26, ,,	July 29, ,,	Genu valga.	Sept. 7, ,,	Ditto	Double.
35	Female	6	Aug. 4, ,,	Aug. 11, ,,	Genu valgum (left).	Sept. 24, ,,	Ditto	Single (left).
36	,,	4	Oct. 2, ,,	Oct. 18, ,,	Genu valgum (left).	Nov. 11, ,,	Ditto	Single (left).
37	Male	2	Nov. 15, ,,	Nov. 16, ,,	Genu valga.	Dec. 12, ,,	Ditto	Double.
38	,,	5	June 29, 1886	July 6, 1886	Genu valgum (right).	Aug. 4, 1886	Ditto	Single (right).
39	,,	7	Nov. 14, ,,	Nov. 16, ,,	Genu valga.	Dec. 18, ,,	Ditto	Double.
40	,,	5	April 26, 1887	May 10, 1887	Genu valgum (left).	June 6, 1887	Ditto	Single (left).
41	Female	4	Nov. 11, ,,	Nov. 22, ,,	Genu valgum (right).	Dec. 14, ,,	Ditto	Single (right).
42	,,	8	March 23, 1888	March 27, 1888	Genu valga.	April 18, 1888	Ditto	Double.

* Readmitted August, 1884, with right patella dislocated on inner condyle. Mechanical loss of base of support.
† Amputation of thigh, Jan. 16th, 1884. ‡ Extreme force put on to break off condyle. Stiff knee.

of the thigh, and so far back as to be opposite the ridge of bone running between the linea aspera and the condyle. Its blade was carried forwards, downwards, and outwards over the front of the femur, with its cutting edge directed to the bone. When its point could be felt under the skin, in the groove between the condyles where the patella would normally have been lying in the flexed position of the limb, the cutting edge was pressed against the bone and the soft parts and periosteum by one slow firm movement in withdrawing the knife. The external wound thus made was about one-third of an inch long, and formed the entrance to a subcutaneous tunnel, running obliquely over the front of the femur, and ending in the cavity of the joint. Adams's saw for subcutaneous division of the neck of the femur was introduced into the tunnel, and the condyle sawn off by directing the edge of the saw straight backwards. The position of the saw could be exactly controlled by feeling its point working

[1] Vide Surgical Lectures, Case 1, p. 52. Smith, Elder, and Co.

to eighteen inches. Tracings on paper are taken of the deformity *prior to operation*, so that a true standard of comparison may exist and the result may be accurately tested.

The operation that I now perform is as follows:—The surface is marked with an aniline pencil and sponge. The central point of the skin over the patella is then spotted (1), and the skin over the rim of the femur (2) on its inner side, about two inches and a half above the patellar spot. The skin which bears spot 2 is next drawn down with the left thumb towards the popliteal space, and so assists in rendering the wound valvular. The knife and saw are shown in the annexed woodcut, the novelty consisting in a deep groove on the back of the tenotome, in which the saw blade slides. By this mechanism all difficulty in entering the saw fairly into the knee-joint is overcome. The knife is entered from spot 2, directly towards

the under surface of the patella at spot 1, penetrates the joint, and certifies its presence there by tilting the patella. Retaining yet the knife *in situ*, the saw is slided in, and a few strokes made in the direct line from spot to spot, so as to groove the femur and thus give proper line and play for the saw. The knife is then removed. The internal condyle is continued to be sawn off until within nearly complete division. Then the saw is withdrawn, and, using the tibia as a lever, it is broken upwards so as to produce straightness of the thigh and leg. Any blood spilt (at times there is none) should be wiped away with dexterity, so as to exclude air. Over the wound is now fixed a pad of collodion with a soft flannel bandage. The outer side of the leg is then splinted (especially guarding the external malleolus from pressure) with a piece of smooth deal and a gum-and-chalk bandage. In three weeks' time the patient's leg will be thoroughly sound, and passive movement may be commenced.

Case 4 is remarkable: for the operation was performed on June 10th, 1879; on August 12th, 1884, I found that on the right knee the patella was dislocated inwards, apparently from the loss of the internal condyloid support; fortunately this displacement did not materially interfere with useful progression.

The Case (15) of infantile paralysis subsequently came to Westminster Hospital to be treated for extensive sores on his feet, due to enervation and the wearing of imperfect boots. After consultation, amputation of the thigh was decided on, and the boy now wears an artificial leg. It enabled me to obtain a valuable pathological specimen of the condition of the lower end of the femur after Ogston's operation; and the bone is now in the museum of the Royal College of Surgeons, London.

Extract from Museum Catalogue (*1885, 2018* A).—"A right knee-joint, with the lower end of the femur divided by a vertical transverse section. The limb was affected with infantile paralysis. The knee was in a position of genu valgum, and the foot of varus. Ogston's operation was performed, with a view of straightening the leg, and a good recovery ensued. The specimen shows that the condyles have their normal relative length, but the internal condyle is slightly widened. Scarcely a trace of the operation remains, the only indication being a groove in the intercondyloid space, and a slight break in the line of the intermediary cartilage."

Ogston's operation was performed on Nov. 29th, 1881, and the limb was amputated on Jan. 16th, 1884.

The lesson that I would teach from this experience is that Ogston's operation in young subjects is a safe and efficient remedy for genu valgum; that the operation itself requires dexterity and a minute attention to detail; that the operation should be undertaken as any other subcutaneous operation (in my own experience there is no necessity for *special* antiseptic precautions); that rest should subsequently be given to the joint, and no persuasion (short of impending gangrene from an improper circlet of bandages) should induce one to interfere with the leg and splint until three weeks after the date of operation. Twenty-five years ago, at Guy's Hospital, I was taught to look upon a punctured wound of the knee joint as a most dangerous accident; and that any surgeon who operated (without urgent necessity) on the knee joint would, in the event of death, lay himself open to a charge of manslaughter. Now, as a local operation for a local distortion, notwithstanding that the subject may be afflicted with general disease, its practice is justifiable, and reflects honour on the surgeon who originated the procedure.

A NOVEL EXTENSION OF THE USES OF COCAINE.[1]

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THE use of cocaine has been hitherto restricted to the production of *local* anæsthesia. Its anæsthetic property is too well known and appreciated to tolerate even a passing reference. Other local anæsthetics are, however, making their way to the front, such as kavin, kandol, erythrophlœum (?) (Sassy). It is wise, therefore, to ask ourselves if cocaine is possessed of other powers besides those which render it of topical value. After a large routine experience of the drug, I do not hesitate to answer that question in the affirmative, and to assert that its capabilities have not been justly estimated. I have used it as a therapeutic, diagnostic, and prophylactic agent for three years, and I now wish to place it in these, and I believe novel, aspects before the profession.

My first grasp of its greater capacity was due to an accident. Soon after the introduction of the alkaloid a gentleman came to me from Servia complaining of constant pain in his face, limbs, and urethra. The urethral pain had existed for five years, and was consequent upon an attack of gonorrhœa. The patient was a well-built athletic man of forty. He had had several severe attacks of malaria. His knee jerks were excessive, and his pupils unequal. He had a frequent desire to vomit, and complained of pins-and-needles sensations in his limbs, which he described as "feeling like small grains of glass fixed in his muscles." He had lost all sexual power. There was no swaying gait, and no residual urine. Believing that his nervous system was thoroughly demoralised by malaria, and that under these circumstances a urethral granulation might have induced and augmented the continual neuralgia he was suffering from, I proceeded to pass an endoscope and examine his urethra. Before doing so I applied, in the ordinary routine fashion, a few drops of a 20 per cent. solution of cocaine to the canal. In about 60 seconds he exclaimed that the neuralgia in his face and limbs was leaving him, and in 120 seconds he was completely free from the pain, which he assured me had been so constant a source of anxiety as to cause him to resign an important and lucrative official position. I found a granulation patch (?),[2] and cauterised it lightly. He rapidly recovered, and, I believe, returned to Servia in anticipation of the then approaching war.

The question that was thus forced upon me was this: Are we able to reduce pain in any part of the body by means of a topical application of cocaine to an absorbent mucous membrane like the urethra? To obtain a perfectly unbiased answer I examined the effects of cocaine upon a large series of decapitated frogs, taking them in spring, summer, autumn, and winter; for, as is well known, their reflex excitabilities vary according to the period of the year. The frogs were decapitated and their toes dipped into a standard solution of sulphuric acid (2 in 1000, Türck). The length of time elapsing before the leg was twitched out of the fluid, and protective movements were made, was noted. Usually this reflex excitability is manifested in ·008 to ·015 seconds. A few drops of a 20 per cent. solution of cocaine were now gently thrown into the cloaca so as to inject the bladder and rectum, and the leg was again dipped in the standard solution. The reflex excitability was found to be greatly diminished. Thus the leg was not withdrawn until after 20, 30, 60, or even more seconds. After many control experiments I concluded that cocaine was possessed of considerable reflex in-

[1] Excerpt from lectures on "The Therapeutical Value of the more recent additions to the Genito-Urinary Pharmacopœia" (THE LANCET, Sept. 1887), read before the Medical Society, Jan. 9th, 1888.

[2] A note of interrogation is used because the old-fashioned endoscope was employed.

hibitory powers. I now worked with stronger acid solutions, and found that cocaine exerted less and less inhibitory control as the strength of the acid solution was increased—i.e., as the stimulus increased. Thus, the leg was almost *immediately* twitched out of a 1 per cent. solution of sulphuric acid, although a vesico-rectal injection of a 20 per cent. solution of cocaine had been administered. With stronger solutions it was evident that cocaine could not prevent the consciousness of the spinal cord nor repress the manifestation of reflex excitability. My conclusions and indications for clinical research were therefore as follows:—1. The application of cocaine temporarily abolishes the consciousness of *weak* stimuli, such as would correspond to slight nerve irritations, neuralgias, &c. 2. The application of cocaine has no power whatever over stronger stimuli, such as would correspond to the pain of carcinoma, inflammation, &c.

I now returned to my clinical field and treated over a hundred cases of neuralgic pains in various parts of the body. In all cases in which the pain was slight and the cause trivial, a freedom from pain was produced in from 30 to 180 seconds by the injection of a few drops of a 20 per cent. solution of cocaine into the urethra. The following are picked illustrations.

CASE 1.—A man entered the out-patient department with a wry neck. Although his discomfort was evidently great, yet he suffered but little if he kept his head resting on his right shoulder. Directly he attempted to bring his head to its proper vertical position severe clonic spasms were induced in the muscles of the face and neck, and he shouted with pain. He stated that he had been forced for three months to sleep propped up in bed, because his wry neck prevented him taking rest in the recumbent position. I examined him very carefully to eliminate bone disease, and finally diagnosed a rheumatic affection of the muscles. Without any explanation, I injected into the urethra thirty drops of a 20 per cent. solution of cocaine and watched the effect upon the wry neck. For 20 seconds there was no change. After 40 seconds the stiffness and the cramp began to leave him. In 60 seconds he was rotating his head excitedly, but with perfect ease and without pain. The relief was complete for some hours. Soda salicylate, potassium iodide, and embrocations relieved him permanently in three or four weeks.

CASE 2.—An educated man, aged sixty-eight, came to me complaining of a severe burning and stinging pain along the course of the left second intercostal nerve, passing from spine to sternum and along the left arm. There were scars of a recent herpes zoster in these positions. A urethral injection of twenty drops of a 20 per cent. solution of cocaine entirely removed the pain in 30 seconds. Complete relief was thus obtained for some hours, and permanent relief after a fortnight's administration of soda salicylate.

CASE 3.—W. S——, aged thirty-eight, married, nine children, came complaining that he had been "suffering" from (worried by?) a burning pain in his glans penis and legs for seven years. He had no syphilis, ataxia, malaria, or vesico-urethral disease. Some relief was obtained from a mixture of potassium bromide and valerian. I then lost sight of him for months. One day he appeared limping, and in evident pain. He stated that for three months the pain in his calves, ankles, and insteps had increased. "Sometimes," said he, "it is the left leg, sometimes the right, now it is both, and I can hardly hobble for pain." I injected thirty minims of a 20 per cent. solution of cocaine into his urethra, and in 90 seconds he was stepping lightly up and down the room. Relief was obtained for some hours, with subsequent recovery.

These cases are certainly striking ones. I give them as uncoloured and as bald as possible. I should hardly like to publish them had not similar results been demonstrated to a large number of students and some medical men, and had not each of my professional *confrères* the power of examining the question for himself.

But there are cases in which the pain is due to some direct and severe source of irritation, and in these cocaine fails absolutely. The following are examples:—

CASE 1.—A patient with carcinoma of cervical glands, and suffering acute pain, experienced no relief from a urethral injection of cocaine.

CASE 2.—Pain from the passage of a spiculated renal calculus. Relief was obtained for one minute by means of a cocaine injection; "then an increase (?) of pain" was experienced.

CASE 3.—Pain due to carcinoma of the prostate. A cocaine injection into the urethra gave slight relief for a minute, "then increased (?) the pain."

We have therefore a clinical corroboration of the physiological results of a cocaine application. We may formulate the matter thus: If pain in any part of the body be due to a *slight* nerve irritation of an unimportant character, a cocaine injection into the urethra will rapidly relieve it. If, on the contrary, the pain is due to severe nerve irritation, a cocaine injection will not relieve it. These facts open a large field in the differential diagnosis of the causes of pain, as well as the just estimation of the amount of pain experienced by neurotics and others. I have used it largely in the diagnosis of urinary diseases. For instance, in cases of renal pain, if a urethral injection of a 20 per cent. solution of cocaine immediately relieves a pain in the kidneys, I diagnose a transient or unimportant cause for that pain, such as congestion, uratic urine or grit, colonic pressure, &c. If, however, the renal pain is uninfluenced by such an injection, I give a more guarded prognosis, and this has been several times verified by the subsequent passage of small stone, or, as in one case, by the development of a renal carcinoma. There are also various vesico-urethral diseases in which cocaine thus used has proved of diagnostic value, as in glans pain, urethral pain, suprapubic pain, &c. Lastly, there is every reason to believe that it will prove of value as a prophylactic agent in warding off, by inhibition, the untoward effects of reflex renal flooding after operations upon the bladder and urethra. I have used the drug with this object for a couple of years, and I hope soon to be able to bring forward physiological as well as clinical evidence upon this point.

THE

TOXIC EFFECTS OF COCAINE PRODUCED BY SUBCUTANEOUS INJECTION.

BY AUGUSTUS W. ADDINSELL, M.B.

As cocaine is now so constantly employed, it is desirable that investigations into its toxic effects should be carefully made, and experiences accurately recorded, to prevent, on the one hand, a feeling of over-confidence in its administration, and, on the other, a reaction resulting in the disuse of a drug so valuable for producing local anæsthesia.

The first case I have to record is my own. Having suffered considerable pain from a small abscess at the root of a tooth, I went to Mr. Maitland, a dental surgeon, and asked him to remove it. He suggested cocaine; I agreed. One grain of the hydrochlorate in powder was dissolved in twenty minims of water, and ten minims injected on each side of the affected molar. In three minutes I was out of pain. The tooth was extracted, and a second root was immediately afterwards taken out. During the operation I had not the slightest sensation of pain. I then began to feel giddy and sick. I felt my pulse; it was very rapid and weak. I had violent palpitation of the heart, with a great thumping at the chest wall, and a slight feeling of suffocation. I then became very talkative and laughed loudly. I remember insisting upon Mr. Maitland getting into his own operating chair, and my wanting to operate; this was politely but firmly declined. I now felt very sick, and tingled all over. I staggered about the room, was very pale, and my pupils were widely dilated. I was perfectly conscious, however. I remained in this condition for thirty-five minutes, when the pain in the gum began gradually to return, my pulse improved, and in an hour after the injection I returned home.

The second case is that of a lady, who called upon me at 7.30 A.M. on Oct. 3rd, complaining of great pain. She had insisted upon walking at that early hour, as she could not rest. I found a large swelling inside the mouth arising from an abscess at the root of one or two decayed molar teeth. I knew her to be very intolerant of pain. I dissolved one grain of the hydrochlorate of cocaine in twenty drops of water, and injected ten drops into the mucous membrane on either side of the swelling; in two minutes the pain had gone. She began to laugh and walk about the room in an excited manner; she threw her arms about, and talked most wildly. Suddenly she fell into a chair and cried out, "Oh my legs, they feel so strange!" She became very pallid; her pulse was very feeble at the wrist, though rapid; she

sighed deeply; complained of tingling all over, and burning pain at the stomach; she clutched at her throat; her eyes were staring and had a dazed expression, the pupils were dilated, and a profuse cold perspiration suffused her face, which was ashy pale. I undid her dress; her heart was bounding and thumping, and the beats were very irregular. I gave her a tablespoonful of brandy, and ordered a bed to be prepared for her. I applied hot bottles to her feet and hot fomentations over the epigastric region. She soon afterward vomited, which appeared to relieve her, as in about half an hour, one hour from the time of injection, she fell into a quiet sleep.

In both these cases the pupils remained dilated for some hours; local anæsthesia was complete in five minutes, and the toxic effects were evident in less than ten minutes. My patient was worse than I was, though I had the larger dose, as in injecting the second of the ten minims into my patient a few drops escaped. In Mr. Pitts' case recorded in THE LANCET of Dec. 24th it appears that a still larger dose was injected: nearly two grains. I also notice that the solution used was prepared at the time—I presume from the powder. This was done in the case of my patient and myself; and it would appear that a solution prepared at the time of operation is stronger and more powerful, as I have had occasion to use more of a solution prepared some time previously and kept in a bottle. Since my experiences recorded above I have never injected more than half a grain dissolved in ten minims of water; and from Mr. Pitts' case and the two here noted I think we may learn that it is not safe to inject a grain; and I believe it will be found that half a grain of the hydrochlorate powder, dissolved at the moment in ten minims of water, will be quite sufficient to produce local anæsthesia, and make these minor operations painless.

A FRACTURE OF THE OLECRANON WHICH NARROWS THE GREAT SIGMOID NOTCH AND OBSTRUCTS THE REDUCTION OF A DISLOCATED ELBOW.

BY JORDAN LLOYD, M.S., F.R.C.S.,
SURGEON TO THE QUEEN'S HOSPITAL, BIRMINGHAM.

A RARE concatenation of circumstances resulted in my acquiring a specimen of a fracture of the olecranon which, so far as my present investigation goes, has not yet been described.

W. T——, aged twenty-eight years, a gentleman's servant, residing at Castle Acre, in Norfolkshire, was placed under my care by my friend, Dr. W. E. Parkes. The patient was a well-grown healthy man. In February last he fell off a bicycle on to his left elbow. The injury was extremely painful at the time; the limb at once became useless, and the joint swelled up with great rapidity. He saw a doctor, who recognised a fracture, within three hours of the accident, and put the arm in splints. A few days later he was seen by the house surgeon at a county hospital, and during eleven weeks subsequently extremely painful passive movements were used two or three times weekly. At the end of this period he saw another medical man, who diagnosed "dislocation." Shortly afterwards the limb became fixed in a semi-extended position. He then went for six weeks into the county hospital, where the arm was bent to an angle, and has continued so until he came under my care.

The man's condition on admission into the Queen's Hospital was as follows:—The left elbow was almost fixed at a right angle; the hand could be moved only a few inches in passive flexion or extension. Supination and pronation were nearly perfect. All the muscles of the limb were wasted. The most easily recognised "landmark" was the cup-shaped head of the radius, which lay immediately under the skin at the outer side of the back of the joint. The olecranon was clearly displaced backwards, but its normal outlines could not be satisfactorily mapped out. At the inner side of the front of the joint the lower edge of the rounded articular end of the humerus could be discerned, and an abnormal fulness continuous with this edge suggested ossific deposit about a misplaced and badly united fractured condyle. The skin over the inner side was reddened, thinned, and closely adherent to the underlying bone. The diagnosis made was oblique fracture of the articular end of the humerus, with displacement of the lower fragment forwards, and dislocation of both bones of the forearm backwards.

On Nov. 25th, under chloroform, an attempt was made to break down adhesions and reduce the dislocation. Considerable force had to be applied before any movement could be obtained, and during the manipulations something was felt to give way, which was explained subsequently by finding that re-separation of the broken condyles had occurred. No alteration in the positions of the misplaced bones was obtained. The limb was carefully padded and put up in angular millboard splints.

On Dec. 10th, the joint had quietened down, and as the patient assured me that he was unable to work with such a limb, because of its limited movements and its sensations of pain, I again put him under cholorform, with the object of excising the lower broken end of the humerus, expecting by this means alone to secure a useful joint. A 2½-inch longitudinal incision was made over the inner side of the joint, and the condyles, which were found to be detached from their bony connexions, were dissected out. When this had been done, the projecting ends of the radius and ulna could not be brought sufficiently forwards, and the movements of flexion and extension were found to be but slightly increased. I then made a corresponding incision on the outer side of the joint, and after some trouble turned the upper ends of the radius and ulna out of the inner wound. These were sawn across on the same level, just above the orbicular ligament. The wounds were sutured and drained, and the limb put up at a right angle and dressed with dry boracic acid dressings. The wound healed rapidly; passive movements were begun during the second week, and he was discharged on Feb. 21st with a sound limb, possessing active extension and flexion.

The chief pathological interest of the case lies in an examination of the excised piece of ulna, which I was

Sawn surface of the inner half of a longitudinal section through the upper end of the ulna and olecranon.

fortunate enough to remove entire and without preliminary snipping off of the olecranon. A fracture runs transversely across the superior surface of the olecranon, nearly an inch from its extreme tip, corresponding closely to the anterior edge of the insertion of the triceps tendon. The fracture extends obliquely downwards and forwards, and ends in the great sigmoid notch at its deepest part, the articular surface being thereby divided into two nearly equal halves. Another fracture appears to have passed from a point half an inch nearer the olecranon tip to join the first fracture at about its centre, separating a small triangular piece from the posterior angle of the whole fragment. The lines of fracture are to be traced in the accompanying illustration, which is a fac-simile drawing of a longitudinal section of the specimen through the centre of the sigmoid notch. The shape of the entire fragment on section is triangular; its apex formed by the tip of the olecranon, its base by the broken edge, its front border by the upper half of the sigmoid notch, and its hinder or upper border by the top of the process. This wedge-shaped fragment has been driven downwards and forwards into the notch, so as to narrow it to a mere cleft, reducing its longitudinal diameter from three-fourths to one-fourth of an inch. The fractured surface of the fragment overlaps the articular cartilage, which has been undisturbed for nearly half an inch. The fragment is firmly united in this position. Whether it was impacted I could not determine. A glance at the illustration will make the injury clear. The end of the radius was normal, and was in proper connexion with the ulna. The excised end of the humerus was formed by its lower articular surface and parts of both condyles.

This case presents many clinical points which are, I venture to think, suggestive and important. I wish particularly to direct attention to four of these—firstly, to the mechanism of the fracture, the displacement of the frag-

ment, and the luxation of the humerus; secondly, to the mechanical obstacles which such an injury presents to the return of a dislocation; thirdly, to the possibility of exact diagnosis; and fourthly, to the question of treatment—immediate and subsequent.

1. Falls on the elbow almost necessarily imply more or less flexion of the joint; the olecranon or the lower end of the humerus, or even both, as seen in the above, may thereby be broken. What it is that determines the particular injury in any case is still matter for speculation. From a study of this specimen it is evident that the man must have fallen on to the extreme top of the olecranon with the joint in acute flexion, and that the same force which detached the fragment drove it forwards into the sigmoid notch, thrusting the humerus out of the articulation, and breaking it obliquely across just above the condyles. When a person falls on to the elbow at a right angle, so that the force travels exactly along a line which would pass within the shaft of the humerus, I think the humerus itself will frequently be broken, cleaved up, as it were, by the underlying wedge-like olecranon; but when, on the other hand, the force passes either in front of or behind that line, especially if the triceps muscle is pulling powerfully at the same time, a transverse fracture of the olecranon will result.

2. A glance at the drawing makes it evident that return of the humerus into the narrowed sigmoid notch was impossible, unless the fragment could be restored to its proper place, and this cannot be looked for when firm bony union has ensued, as seen in this specimen.

3. An exact diagnosis will be a matter of extreme uncertainty. In the presence of inflammatory swelling it is quite out of the question; but when swelling has entirely subsided, I think that, with my experience of this case, I should be able probably to recognise another. The impossibility of reduction, the absence of the characteristic sharp outlines of the top of the olecranon, the shortening of the ulna, measured from the top of the olecranon to the styloid process, would arouse my suspicions.

4. With regard to treatment. I can see no reason why shortly after the accident the parts might not have been moulded into position under an anæsthetic. It is to be regretted that my patient's injury was not thoroughly overhauled under the influence of ether. If all doubtful injuries were examined under anæsthesia at once, the number of disabled limbs, and the amount of physical suffering after accidents, would be enormously reduced. Viewed by the light of subsequent discovery, I cannot see that anything short of complete excision could have benefited the patient at the time when I first saw him.

No mention of this variety of fracture is to be found in the works of Erichsen, Holmes, Heath, Agnew, Astley Cooper, Bryant, Gant, Ashhurst, Chelius, or Hamilton. Stimson[1] refers to three cases reported by Quintin "of incomplete fracture of the olecranon; the surface articulating with the humerus was broken, the dorsal portion was unbroken; in all the swelling was moderate, the pain severe, flexion and extension complete, but slow. In the first case, seen a week after the accident, a small prominence could be felt on the side of the olecranon, and behind it was a notch; the upper end could be sprung back a little. In the second case a short shallow groove could be felt on the outer side of the olecranon at its base; and in the third the olecranon could also be sprung." (In none of these were the joints examined by dissection.) "Corroborative testimony is said to be furnished by experiments upon the cadaver made by Madelung and Lesser, who found that when the blow fell directly upon the olecranon, the forearm being partly flexed, the result was a fracture of the olecranon from without inwards (from the dorsum towards the articular surface), the end of the process being bent into the olecranon fossa." Commenting on the latter, Stimson says: "I fail to understand the mechanism as it is described, and confine myself, therefore, to this brief restatement of the author's views."

The above case establishes beyond doubt not only the possibility of incomplete fracture of the olecranon, but also that such fracture may be driven forwards into the sigmoid notch, dislocating the humerus, and making its reduction extremely difficult if not altogether impossible. The specimen has been exhibited to the members of the Birmingham and Midland Counties Branch of the British Medical Association, and will be lodged in the museum of the Royal College of Surgeons.

[1] Treatise on Fractures, p. 420. London: J. and A. Churchill.

MORAL INSANITY.[1]

BY JOSEPH WIGLESWORTH, M.D., M.R.C.P. LOND.
(RAINHILL ASYLUM.)

THE proposition was enunciated that morality is a function of the brain which has been gradually developed during long periods of time, and the importance of the study of mental phenomena from a developmental standpoint was insisted on. The origin of the faculty might possibly be found in the social instincts displayed by numerous classes of animals, pleasure in and profit from one another's society being the germ of the altruistic feelings. Savages, generally speaking, exhibited a remarkably low development of the moral sense, although significant exceptions were met with. Militant activities were essentially egoistic in their nature, and it was only in a developed industrial society that any high development of the altruistic faculties was to be looked for. There was no absolute standard of morality, but actions were to be looked upon as moral or immoral according to the development which the moral faculty had attained to in any community. The distinction which was made between idiots or imbeciles and ordinary insanity held in the domain of feeling, so that those who exhibited abnormalities of the moral sense might be divided into those who were congenitally deficient in this faculty, or who, from disease, had lost it early in life—the so-called moral idiots and imbeciles; and those who, having once had their full share of moral feelings, had lost them in adult life as the result of disease, forming the class of morally insane persons proper. Moral idiots or imbeciles were children who, with little or no impairment of intellect, showed great deficiency or almost total absence of the moral faculties; and, what was of great importance, *they were incapable of acquiring them.* The ordinary discipline of life produced but little effect on them. Such children usually came of an insane stock. On the developmental theory we might find an explanation of such cases. The defect of cerebral organisation existing in moral idiots might be considered to be on a level with the normal organisation of certain low races of savages; and hence a moral idiot might be considered to be a reversion to a lower type of animal structure, to a lower level of evolution. Morally insane persons proper exhibited a change in their affective nature, their altruistic feelings becoming greatly impaired or altogether lost. Moral insanity might exist by itself, but it was more usually a stage in the development of intellectual insanity. Thus, at the commencement of an attack of mania, moral change might show itself for some time before intellectual change became apparent, and it might remain after the disorder of intellect had passed away. Similarly, at the onset of general paralysis of the insane moral depravity might occur some time before any mental derangement showed itself. So also with senile dementia. Epileptics also, at the times when their fits were troubling them, often showed great change in their moral nature, which might be quite temporary. Again, as the result of a blow upon the head a total change might be produced in the affective side of a man's nature. Such cases left no room for doubt that morality was a function of organisation. These abnormalities all found their explanation in the developmental hypothesis. The very delicate adjustments of the human organism to its social environment, which make up what is called the moral nature of the individual, were of comparatively recent acquirement, and, this being so, they were peculiarly obnoxious to disease or decay, being affected before the older and more firmly organised faculties. Hence the moral faculties were often the first to be affected when the cerebrum was the subject of slowly progressing disease.

[1] Abstract of paper read at the Liverpool Medical Institution, March 15th, 1888.

MANCHESTER AND LIVERPOOL HOSPITAL SATURDAY FUNDS.—The net amount resulting from the match played in Manchester on March 17th, between the Lancashire County Football Club and Middlesex, was £45 19*s.* 3*d.* This has since been augmented by the County Club out of their funds to £100, of which £75 have been paid to the Manchester Hospital Saturday Fund and £25 to the Liverpool Hospital Saturday Fund.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

MASKED SCARLET FEVER.

BY J. EDWARD SQUIRE, M.D., M.R.C.P.

THE infection of scarlet fever is frequently and largely spread by the slighter cases which escape notice; these are often not seen by any doctor in the early stages, when isolation should commence, and even if seen the diagnosis may be difficult or uncertain until the more advanced stages, as exemplified by the following cases.

A girl, Emily C——, aged nineteen, came to me at St. George's and St. James's Dispensary on Sept. 7th, 1887, complaining of headache and sore throat. The throat was seen to be red over the tonsils and soft palate, with a patch of membrane on each tonsil. Her illness began on the previous day with heats and chills; no rash was to be seen, nor did desquamation follow, though the girl was under observation for two months. She had come from Battersea to work at her aunt's, in whose family are two young children and a girl of her own age.

On Sept. 14th, just a week after Emily C—— was taken ill, the youngest of this family, Beatrice P——, a girl two years old, had some spots on the chest and back. These spots were distinct papules, with clear skin between, and were confined to the parts of the body under the clothing. The child was not ill, did not complain, and was not even noticed to be languid or restless. There was no sore throat.

On Sept. 19th this child's brother, John P——, aged five years, was brought to me because he was said to have "blisters on his hands and feet," which were found to be really due to desquamation of the skin of the palms and soles. An examination of the chest showed fine branny desquamation there also. The face appeared full and puffy. There was a large quantity of albumen in the urine. He had been noticed to be languid and dull for a day or two, and then some spots were seen on his chest, but none on his face, which, however, was very red. He also complained of sore throat, but was not kept away from school. The spots and redness lasted for a week or ten days, and the child was languid and easily tired all this time—an unusual thing for him.

The elder sister of these children, who slept with Emily C—— while she was ill, had a sore throat, but no marked feeling of illness, and no rash.

Here we have four cases of scarlet fever running their course in members of the same household without recognition, until, when convalescence was established, desquamation and albuminuria in one case showed what had been going on. The elder patients continued their work throughout, and the children attended school without a break, and probably spread infection.

Two other cases came under my observation about the same time in which scarlet fever was not suspected until desquamation occurred. In these cases, also, no attempt was made to isolate the patients.

Mary B——, aged fifteen, felt her throat slightly sore before Sept. 10th, on which day she believed she caught cold in going to the theatre. On the 11th she felt chilly, and sat over the fire most of the day. On the 13th, 14th, and 15th, a rash, "like sago grains," with a reddish appearance of the skin between, was noticed on the back of the neck, the chest and thighs, appearing in the order stated, and fading away in one part as it came out in another, leaving a brownish patch behind. Her throat did not trouble her after the first two days. On the 16th desquamation began round the neck and armpits. Two or three days later, when I saw her in consultation, the skin was peeling in the armpits, over the anterior fold of the axilla, in the fold of the groins, and over the lower part of the abdomen. The patient had not been confined to her bed during her illness, and had not been separated from other members of the family.

Charlotte F——, aged six years, seemed weak and tired on Sept. 6th, and wanted to go to bed. Next day red patches were noticed on the shoulders and neck, which on the following day had extended to the thighs, where the eruption was more papular. The child also complained of pain and stiffness in the fingers. About Sept. 17th, she began to desquamate in the groins and about the tips of the fingers. I saw her with Dr. Foy on the 22nd, when there was fine scurfy desquamation on the right side of the chest and about the axillæ. She had been kept at home during her illness, and chiefly in bed, but not separated from other members of the family.

In both the above cases, no suspicion of scarlet fever had occurred to the friends during the illness, or to the medical man who was attending, until desquamation suggested the true nature of the illness.

A CASE OF SCIRRHOUS CANCER OF THE PYLORUS; RUPTURE; COLLAPSE; DEATH IN TWENTY HOURS.

BY C. J. WEST, L.R.C.P. LOND., M.R.C.S.

As cases of abdominal mischief are always somewhat obscure, and as one is not always able to obtain a post-mortem examination to verify one's diagnosis, I think the following case may perhaps be of interest.

I was called on Nov. 17th, at 10.15 P.M., to see a lady aged fifty-six, a former patient of mine, who had been suddenly taken very ill. When I arrived I found her complaining of intense abdominal pain; her expression was anxious, and her countenance pallid; pulse full, 84; temperature normal. She told me she had been suddenly taken with violent pain in the abdomen about a quarter of an hour previously, when lying still in bed, as, having been up late the evening before, she had stayed in bed all day. She had formerly suffered from gastritis, gastrodynia, and dyspepsia for some years. On examining the abdomen, it was completely flaccid, and not specially tender in any part; pain not fixed, but referable to different parts—i.e., bladder, kidneys, chest, upper portion of abdomen, then sides. Hypodermic injections of morphia were given, and her condition greatly improved. In the morning she was comparatively well, sitting up in bed and reading the newspaper. On Nov. 18th, at 3 P.M., I was suddenly summoned, and found the abdomen tender and still flaccid, the extremities cold, and the heart sounds very weak. I ordered a mustard poultice over the cardiac region, and one of linseed and mustard over the abdomen, with the employment of hot bottles; also twenty minims of ether (pure) were injected hypodermically every half-hour. I at once telegraphed for Sir Edward Sieveking, who had previously seen the patient. A catheter was passed and about three ounces of limpid urine drawn off. I soon foresaw, however, that my efforts were useless, as she was sinking rapidly. At this stage Dr. Coleman kindly saw her at my request, and she was kept alive by the application of external warmth, brandy, and injections of ether hypodermically, until 7.15 P.M., when she died, retaining consciousness until the last. Sir Edward Sieveking did not see her until after death, but then could not detect anything abnormal in the abdomen.

Necropsy.—On examining the abdomen, the peritoneum was found to contain a quantity of fluid; the intestines were much inflamed, and covered with effused lymph; bladder, kidneys, and uterus normal. On tracing the duodenum upwards, a hard mass was found infiltrating the walls in its upper part, also at the pyloric end of the stomach; in the centre of this growth, about half an inch above the pyloric valve, was a rent in the stomach about the size of a shilling; the entrance to the duodenum was much contracted, and it was infiltrated with this hard growth.

The case presents several points of interest in that extensive cancer of the stomach existed, and must have existed for some considerable time, with apparently little or no fixed pain, or definite indication of abdominal mischief. The tenderness at the epigastrium occurred at periods of some months, lasting only two or three days; the thickness over the pylorus was only detected once, and as the condition of the patient was so good no special stress was laid upon it. Then came the sudden rupture whilst lying in bed, and the intense pain at the time; then a stage in which the patient recovered almost to feeling herself again for some hours; then sudden collapse and death. Sir Edward Sieveking has

kindly furnished me with a few notes taken by him at different times.

"In 1872 the patient suffered from gastric trouble (gastrodynia); cured. In 1884 she first complained of pain, though slight, in the abdomen. On Nov. 11th 1887, there was return of pain in the right hypochondrium, at times severe; sick once; pulse 84; tenderness at epigastrium; thickness over pyloric end of stomach; no hæmatemesis. This was very irregular, and she became much better the day before her death, entertaining a large party at her house, at which she was cheerful, and danced.

RECTAL CONCRETION.

By W. J. TYSON, M.D., F.R.C.S.Eng.

THERE are one or two points besides those mentioned by Dr. Ingleby-Mackenzie in connexion with the above subject which I think are worth recording.

When the constipation has lasted for a few days an apparent diarrhœa may come on; and this symptom is apt to mislead one in the diagnosis of the case, unless the abdomen and rectum be examined. The above class of case resembles very much that of incontinence of urine, the result of distended bladder. There is a distended viscus in both, there is an overflow in both, and also in both there is often abdominal pain, due in the one to the stretching of the bladder, and in the other to peristaltic action. In the case of the bowel distention, opium, if given, still further mystifies the position. As a rule, aperients and injections will fail in the cases I am describing, the former only jamming up the rectum still more, and the latter fails to get any hold in the bowel, and so returns almost immediately, or the nozzle gets plugged with fæces on its introduction. The treatment is: Dislodge the lumps (made harder by the diarrhœa) with fingers or spoon, followed by an injection.

A CASE OF EMPYEMA.

By DAVID LLEWELLYN, L.R.C.P.L., M.R.C.S.

ON March 12th, 1887, I was called to see a child, Edgar M——, aged two years and five months, whom I found to be suffering from left pleuro-pneumonia. The temperature ranged from 103° to 104° until the eighth day, when it fell to 99°. On examining the chest at the expiration of this time, dulness was very pronounced up to a line drawn horizontally an inch and a half above the angle of the scapula; and on auscultating over this region the respiratory sounds were exceedingly weak, above the line very harsh, and the percussion note somewhat hyperresonant. The apex of the heart was displaced to the right side to the extent of an inch and a half. In spite of medicinal treatment the effusion gradually rose, until at the end of a month it reached a level a little below the spine of the scapula, and the greater portion of the heart became displaced to the right of the sternum. There now appeared a small fluctuating swelling over the third intercostal space, an inch external to the costal cartilages. I acquainted the parents that nothing could be done except to operate, to which they had a great aversion. At last they consented. I made a free incision into the tumour, and let out a large quantity of pus, at the same time placing the child in the prone position so as to accelerate its exit, then placing four inches of split drainage tube into the cavity. The wound was dressed with lint soaked in carbolic acid (1 in 40); over this were placed several layers of ordinary absorbent wool, and finally a flannel bandage. The dressings were changed three times a day for the first week, and afterwards night and morning. The child now began to take more nourishment, and asked for his toys. The physical signs improved; absolute dulness gave way to partial resonance, and breath sounds were to be heard over the previous dull area, evidently showing that the lung was gradually expanding. Friction sounds were very audible all over the lower part of the affected side, and the fingers became clubbed, but not the toes. I gradually shortened the drainage tube, and about two months from the operation removed it altogether, leaving a sinus discharging a small quantity of thin pus. Unfortunately, a few weeks afterwards I discovered that the chest had begun to fill again I therefore determined to open up and enlarge the sinus, and put in as large a drainage tube as the space between the ribs would allow. With the assistance of my friend Dr. Thurstan, who kindly gave the anæsthetic, I made an incision two inches in length parallel with the upper border of the fourth rib, cutting through the pectoral and intercostal muscles into the thoracic cavity. About a pint and a half of fetid pus escaped, and the pleural cavity was well washed out with a warm saturated solution of boracic acid. Five and a half inches of drainage tube were inserted. The wound was dressed in the same manner as in the previous operation. The subsequent treatment consisted in washing the cavity out twice a day with the aforesaid solution and the gradual shortening of the tube. Half-drachm doses of syrup of iodide of iron in water were ordered three times a day and a diet of milk, beef-tea, and mutton broth, with a little stimulant. He made an uninterrupted recovery, and eight weeks afterwards the little fellow was convalescent and running about. The lung appears to have fully expanded.

A Mirror
OF
HOSPITAL PRACTICE,
BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Procemium.

ST. THOMAS'S HOSPITAL.

CARIES OF THE FIFTH LUMBAR VERTEBRA, LEADING TO CHRONIC RECTAL OBSTRUCTION, WITH EXTENSIVE DESTRUCTIVE ULCERATION IN THE PERINEUM; REMARKS.

(Under the care of Mr. G. H. MAKINS.)

THE following case seems of importance as illustrating the well-known difficulty in diagnosing disease of the lower lumbar vertebræ, and from the somewhat unusual manner in which it led to rectal obstruction.

E. R——, aged thirty-seven, married, was admitted on Aug. 18th, 1887. She has had seven children, five of whom are still living, and three miscarriages. Father living and healthy; mother bedridden from paralysis; brothers and sisters healthy. The patient has always enjoyed fair health; she, however, had an attack of pleurisy eleven years ago. With the exception of the history of miscarriages, no evidence of syphilis was obtained. Her present illness commenced fifteen months before admission with the development of two small hæmorrhoids; these gave rise to pain and hæmorrhage in connexion with defecation, and one month later they were removed. The operation gave no relief; a discharge of pus and blood continued from the rectum, and a large ischio-rectal abscess formed in the left fossa, which was opened four months after the commencement of the symptoms. Since that time the wound continued steadily to increase superficially by ulceration, and at the end of ten months she was admitted into the Lock Hospital suffering from diarrhœa, and with a considerable ulcer around the anus. She was there treated somewhat energetically on the supposition of syphilis, but no improvement was obtained, although she was brought fully under the influence of mercury. She lost flesh steadily during her stay there, very rapidly during the last two months, and was discharged as incurable.

State on admission.—Extreme emaciation and feebleness; pulse 90, only just perceptible; temperature subnormal, 97·6°; gums spongy; constant painful diarrhœa, defecation being involuntary. She lies helplessly on her back; the lower extremities are swollen and œdematous, especially the left; and there is a small quantity of free fluid in the abdominal cavity. The superficial abdominal veins are much distended, but no internal tumour can be discovered. Urine: sp. gr. 1016, clear, acid, no albumen. Thoracic viscera healthy. On examination of the perineum, an extensive ulcer was seen, reaching posteriorly beyond the tip of the coccyx, laterally to within an inch of the ischial tuberosities, anteriorly destroying the lower inch of the posterior vaginal wall; at the deepest part

of the ulcer is the opening of the rectum, and the ulceration spreads upwards an inch and a half, entirely destroying the sphincter, and causing a constriction into which only the tip of the little finger can be inserted. The surface of the ulcer generally is smooth, covered with imperfect granulations of a pale-red colour; there are a few small superficial sloughs, but no points resembling tubercles. The edges are very little raised, not indurated, the healthy skin almost meeting the ulceration; there are no isolated nodules around. Enlarged glands in both groins; those on the left side are suppurating.

The extreme feebleness of the patient forbad any immediate surgical interference, and it was hoped that rest and good diet would improve her condition enough to allow of the ulcer being freely scraped, and the stricture, if necessary, divided, to ensure free passage to the fæces. In spite of some fluctuating improvement, however, she gained little ground, and on account of the great suffering caused by the passage of the motions over the ulcer it was considered better to perform left lumbar colotomy. The ascitic fluid present on admission had become reabsorbed, and the operation was performed without difficulty. The colon was well drawn out and sutured to the lumbar wound on Sept. 5th, and on the 9th the bowel was opened. The operation wound at that date had healed throughout by first intention. She suffered no ill effects from the operation, and the outlet sufficed to divert the flow of fæces over the ulcer; but the general condition did not improve, and she died from exhaustion, somewhat increased by two small hæmorrhages from the bowel eight days later.

A post-mortem examination was made by Dr. Sharkey on Sept. 14th, when the following condition was found. The body of the fifth lumbar vertebra was the seat of caries anteriorly. The process had not extended deeply, producing merely a rather deep groove. The intervertebral discs were unaffected, but a small area of the surface of the first sacral vertebra was also carious. In connexion with the bone disease, abscess cavities existed on both sides of the pelvis, but they contained no accumulation of pus, as they opened into the rectum, one about an inch and a half above and to the left of, the other immediately above, the constriction. The rectum was dilated considerably above the stricture, which consisted of a circular ring of granulations supported by a firm base of inflammatory new formation; and immediately above some ulceration existed; while four circular rugged ulcers were found higher up, one of which, near the colotomy wound, had apparently been the source of the hæmorrhage shortly preceding death. The external ulcer was much of the same appearance and extent as on admission. The left common iliac vein was plugged, the thrombus being of some standing, its formation being evidently due to the pressure of the abscess descending on that side. Douglas's pouch was obliterated by adhesion of the contiguous structures. The Fallopian tubes were distorted and adherent to the back of the uterus and cæcum; both were distended with a soft, yellowish, thick fluid. Both ovaries were fixed, and contained a similar semi-fluid, yellowish material. The bladder was healthy, and not adherent to the uterus. The right ureter was compressed by inflammatory exudation at the pelvic brim; it contained some pus at that spot, and was almost completely blocked; its lining membrane was healthy above, but a moderate hydronephrosis and dilatation of the ureter existed. Both kidneys were exceedingly pale and transparent, but not the seat of amyloid degeneration. All the other organs were anæmic but healthy. The colotomy wound was healed, and there were no signs of inflammation in its neighbourhood. Microscopic examination of the ulcer revealed merely a dense inflammatory induration, consisting almost entirely of small-celled infiltration, with no signs of organisation. In no part were tubercles to be discovered, and careful and repeated examination failed to show the presence of tubercle bacilli.

Remarks by Mr. MAKINS.—As will appear from the above account, no symptoms were present to point to spinal caries except the perineal ulcer; and this from its shallowness, wide superficial extent, and general unlikeness to the fistulæ often giving vent to fæces usually met with, together with the small amount of discharge, was of little diagnostic aid. A thorough rectal investigation might, no doubt, have thrown more light upon the case, but this unfortunately was impracticable, as any examination caused extreme pain, and the patient's general condition was so serious as to preclude anæsthetisation unless absolutely necessary. Hence, one had to be satisfied with external examination, and here, I think, the characters were very misleading, rectal obstruction from pelvic cellulitis or abscess, although not uncommon, being usually of a more extensive description than the mere annular stricture here existing at the extreme lower limit of the bowel, and apparently due to spread of the ulceration from without. Vertebral disease being unsuspected, the main diagnostic interest centred in the nature of the ulceration. The appearance negatived at once the question of epithelioma, although the ascites, the pressure on the left iliac vein, and the enlargement of the superficial abdominal veins still left the possibility of internal malignant growth, even in the absence of a palpable tumour. The flat non-indurated character of the sore, however, seemed to place it more naturally in the category of either a gummatous or tubercular ulcer; but here, again, difficulties arose. In favour of syphilis, the occurrence of miscarriages was the only evidence to be adduced; while the absence of any other signs and the ill success accruing from energetic anti-syphilitic treatment seemed strongly against it. Almost the same difficulty existed in the case of tubercle: no heredity could be traced, neither was any evidence forthcoming of tuberculosis of internal organs, but this view being somewhat supported by the anterior presence of the ischio-rectal abscess and the still-existing enlarged inguinal glands, it was adopted as the most probable. Microscopic examination has, however, shown the whole case to be of a simple inflammatory character. Lastly, with regard to the treatment, it only remains to remark that death from exhaustion, due principally to the suffering from painful defecation, might perhaps have been averted, or at any rate considerably postponed, by an earlier colotomy.

ANCOATS HOSPITAL, MANCHESTER.

A CASE OF HYDRONEPHROSIS; NEPHRECTOMY; RECOVERY; REMARKS.

(Under the care of Mr. E. STANMORE BISHOP.)

MRS. H——, aged fifty, a thin, anæmic-looking woman, looking fully her age, was sent to the hospital by Dr. Frank Holmes. Five years ago the patient fell downstairs when five months pregnant, striking her head against the step and becoming unconscious. She is not aware that any other part of the body was injured. The next morning she aborted, losing a good deal of blood. She has had some pain across her back for about ten years, which, however, has been much worse during the last two. During the last year she has been unable to lie on her left side, or to stoop or carry any weight. She has suffered from leucorrhœa, and attributed the pain in her back to this. During the last two years the urine passed has been scanty, and she has noticed that when the pain was most intense the urine was less. She never passed blood or sand, but the colour of the urine varied. She has had much flatulence and constipation. Her feet were sometimes swollen, but not more on one side than the other. She had never noticed any tumour, nor was it mentioned by any of the medical men she consulted until five weeks since, when seen by Dr. Holmes, who pointed it out, being consulted by her for some localised peritonitis.

On examination, her abdomen was flaccid and easily compressible everywhere except on the left side, where a semi-solid mass could be felt; posteriorly no outline could be made out, nor any limitation of the dulness on percussion. Superiorly there was a clearly defined rounded edge, which could also be traced anteriorly extending to the middle line, and just beyond the umbilicus, passing downwards and outwards towards the ilium, about the level of the anterior superior spinous process. Below, in front, to the right and above, were clear percussion sounds. The boundary line was bossed with large curves. Anteriorly the tumour appeared to contain fluid; posteriorly it was of firmer consistence. It was movable, very slightly upwards or downwards, but markedly backwards and forwards.

The question of ovarian tumour was eliminated by the clear sound inferiorly, and the diagnosis appeared to lie between splenic and renal enlargement. As no notch could be felt, and there was the previous history of some urinary irregularities, the balance of probability was that it was renal. Puncture with a long hypodermic needle showed its entrance into a large cavity, and fluid withdrawn by it was clear, straw-coloured, and deposited some hæmocytes and flat epithelial cells. The fluid contained no albumen, hydatid

hooklets, or pus. The tumour being diagnosed as renal, hydatid disease and pyonephrosis were excluded by the result of the hypodermic puncture. Carcinoma, though probable at her age, was negatived by the absence of pain on handling, the general smooth outline of the mass, the entire absence of hæmaturia, and the general appearance of the patient. Cystic sarcoma, or simple hydronephrosis due to obstruction in the ureter, appeared to be the two conditions most likely to be met with. If the latter, simple incision with drainage was intended; but during the operation the renal tissue was found to be so disorganised that it was judged advisable that the whole should be at once removed, which was done.

On Dec. 10th, 1887, the patient being prepared, Mr. Bishop removed the kidney by the lumbar horizontal incision, midway between the iliac crest and the margin of the ribs, starting from the outer edge of the erector spinæ, and passing diagonally downwards and forwards for a distance of four inches. The kidney being exposed, it was tapped, but only a small quantity of brown grumous fluid escaped; it was afterwards found that the trocar had only penetrated the substance of the kidney, opening into a smaller cavity produced by the disintegration of its substance. The finger introduced by the side of the kidney rapidly broke down the cellular tissue around, except at the pedicle and upper extremity; the thicker band at this latter point being then divided by scissors, the kidney was drawn out and the vessels secured by a double silk ligature passed through the pedicle with a blunt aneurysm needle, and tied in two parts. The ureter was also secured by a second ligature applied as low down as possible. The kidney was then separated by scissors. On removal the descending colon bulged into the cavity formed, and a strip of capsule apparently torn off was carefully cut away by scissors. The ilio-inguinal and ilio-hypogastric nerves were seen bared for about one inch of their course, and loose for that distance from the wall of the abdomen; they were carefully replaced. There was no bleeding of any importance from the cavity. The ligatures around the vessels and ureter were slightly drawn up and examined, but, no oozing being seen, they were cut off short, and the parts allowed to fall into position. At one point, near the upper extremity of the anterior wall of the cavity, a small opening into the peritoneum was seen, and accurately closed by a catgut suture. Two large rubber drainage tubes, with wide fenestræ, were used, the one passing towards the vascular pedicle, the other downwards towards the ureter, and both coming out at the posterior end of the incision. The cavity was then washed out with warm perchloride solution, the incision sewn up, and wood-wool pads, dusted with iodoform, were placed over and around the wound, the whole covered by absorbent cotton wool and a many-tailed flannel bandage. The operation lasted an hour and a half, and the patient was removed to a bed in the same room. At 2.30 P.M. the temperature had sunk to 97°, so an injection of brandy and hot beef-tea, with thirty minims of tincture of opium, was given per anum, and hot bottles placed around the patient. This was repeated at 4.30 P.M., and at 6.30 another injection of beef-tea, brandy, and twenty minims of tincture of opium. Eighteen ounces of urine were drawn off. Temperature 99°. At 8.30, there being some pain, five minims of solution of morphia were injected hypodermically; and at 10.30, the temperature having gone down to 97.6°, and the patient appearing collapsed, twenty minims of ether and three minims of morphia were again injected in the same way. The temperature at 12 P.M. was 96·2°. Nine ounces of urine were again drawn off.

Dec. 11th.—By 2 A.M. the temperature was 97·6° and the patient not so collapsed. Complaining of pain. Five minims of morphia solution given hypodermically. This was repeated at 11 A.M., and at 5 and 9 P.M. During the day twenty-one ounces of urine were drawn off. At 9 P.M., the discharge showing outside the dressings, they were changed and the tube cleaned. During this time ice was given by the mouth, and beef-tea and food essence were given. There was some sickness.

12th.—Five minims of a solution of morphia were injected at 10 A.M., there being still some pain. Thirty-three ounces of urine drawn off.

13th.—Temperature normal at 1 A.M.; fell to 79° at 1.30 P.M.; rose to 95° at 4.30 P.M., and commenced to fall again, reaching 96° at 4.30 A.M. on the 14th. During the period of low temperature the patient passed some very fetid urine containing pus and phosphates, and became very collapsed. Twenty-five minims of ether were injected hypodermically, and an enema of brandy, beef-tea, and twenty grains each of chloral and bromide of potassium were given by Mr. Hunton, the senior house surgeon. The patient rallied, and the temperature gradually rose.

14th.—A good deal of retching and sickness. Temperature 97° at 7 A.M.; reached 98° at 11 A.M.; fell to 96·2° at 1.30 P.M.; gradually rose to 99° at 7.30 P.M., when an enema was given, followed at 11 P.M. by a normal stool. Wound dressed the second time. The line of incision was healed, except at the point of exit of the tubes, and some brownish fluid was washed out by syringing. There was no smell, or sign of pus. Drop doses of ipecacuanha wine were given to relieve the retching, which was very troublesome and lasted until about 10 A.M. on the 16th. Thirty-one ounces of urine were drawn off, not fetid.

15th.—Temperature fell to 97·2° at 3.30 A.M., and again at 12 A.M., rising to the normal at 4 P.M. Retching continues. Urine 31 oz., not fetid.

16th.—Temperature normal, reaching 99° at 2.30 P.M., falling again to normal at 6.30 P.M. As the retching continued, the ipecacuanha wine was stopped, and drop doses of carbolic acid substituted. This had the desired effect, and the sickness ceased. Urine 20 oz.

17th.—Temperature generally normal; fell to 97·6° at 9 A.M., and rose to 99·2° at 7 P.M. Wound dressed a third time, and one tube—the upper—taken away. Two stitches were also removed. Very slight brownish discharge. Amount of urine 37 oz.

18th.—Temperature 98·8° at 8 A.M.; fell to 97° at 10 A.M.; rose to 100·2° at 5.30 P.M., but fell to 99° at 12.30 P.M. Patient is restless, and it is difficult to keep her dressings in place. She complains chiefly of pain over the course of the ilio-inguinal nerve, not to any extent in the wound or over the site of the cavity. The wound was dressed again, chiefly in order to replace the dressings in position, as the patient was rather troublesome to manage. Amount of urine 14 oz.

19th.—Temperature 99° at 3.30 A.M.; sank to 97·6° at 10.30 A.M.; rose to 100° at 5 P.M.; sank to 98° at 7.30 P.M., and rose again at 10.30 P.M. to 100·2°. All stitches were removed. The tube is clear, and perchloride solution injected returns clear; but there is a small tender spot above the tube. Since the 16th has been taking chicken, fish, oysters, dry toast, &c., and takes them fairly well. Urine 19 oz.

20th.—Temperature normal to 99° all day; rose at 6.30 P.M. to 100.2°, but fell to normal at 8.30 P.M. Wound dressed; slight blush around it. Urine 26 oz.

21st.—Temperature 98° till 12 noon, when it reached 99°, and at 4.30 P.M. 99·8°, falling to normal at 9 P.M. Urine 18 oz.

23rd.—Temperature 97·6° at 4 A.M.; 98° at 4 P.M. Wound dressed. Tube removed. Looks very well. Urine 24 oz.

24th.—Temperature 99° at 1 A.M.; fell to 97° at 8 P.M. Urine 38 oz.

25th.—Temperature 97° at 4 A.M.; rose to 98·4° at 4 P.M.; fell to 97·2° at 8.30 P.M. Urine 25 oz. Bowels moved twice.

26th.—Temperature 97° at 2 A.M.; rose to 98·4° at 8 P.M. Urine 20 oz. Wound dressed. Complains still of pain along the track of the ilio-inguinal and ilio-hypogastric nerves. Urine 20 oz.

28th.—Temperature 97·4° at 4 A.M., 8 A.M., and 6 P.M. Urine 11 oz. Ordered confection of senna.

31st.—Temperature 98·4°. Bowels moved three times. Urine 14 oz. Wound dressed.

Jan. 1st, 1888.—Temperature 98·4°. Bowels moved once. Urine 9 oz.

3rd.—Temperature 99° morning; 100° night. Dressed wound, and about three inches of narrow tubing were passed into the still open sinus leading down towards the ureteral ligature, giving exit to about half a drachm of watery-looking fluid. Amount of urine passed 21 oz.

4th.—Is much easier. Temperature 98·4°. Urine 21 oz. From this time the wound was dressed daily for a week. Pain was still complained of along the course of the nerves bared during the operation. Menthol was applied externally, and aconite, with the result of obtaining relief, but the pain recurred still more or less.

On the 10th the tube was again shortened, there being almost no discharge. The temperature remained normal, and the urine passed averaged 24 oz. in the twenty-four hours.

On the 11th, in the evening, the temperature rose to 100°, but fell again the next day, and remained steadily normal

to the 21st, when again the evening temperature marked 100°, becoming again normal or slightly subnormal until Feb. 5th, on which day the evening temperature was 100·4°, and on the 11th, 100° between these dates; and until her discharge on the 23rd the temperature was pretty regularly 98° in the morning and 98·4° in the evening. The amount of urine secreted increased to 20 oz. on Jan. 30th, 32 oz. on Feb. 3rd, 38 oz. on the 16th, and 39 oz. on the 22nd, the day before her discharge.

On Feb. 23rd, she was sent to the convalescent home. The wound had perfectly healed, with the exception of a very small sinus, which led apparently in the direction of the ureteral ligature. The patient was in good condition and spirits, and was taking food well.

Remarks by Mr. BISHOP.—So much has lately been said as to the inadvisability of nephrectomy in such cases without a previous trial of nephrotomy and drainage, with a view to the possible uselessness of the remaining kidney, that it may be advisable to justify in advance the action taken. Before operation the amount and character of urine were duly noted. No change took place whilst under observation in the size of the tumour or the amount of fluid secreted, so that, although there was a history of such variation in the quantity of urine coincident with variation in the amount of pain felt some time since, it appeared evident that the obstruction, whatever it might be, was now complete, and had been for some time, judging from the size of the tumour felt. Whilst, therefore, the affected kidney was doing no work, the opposite organ was working well, and had been gradually accustoming itself to its increased burthen, so that entire removal would not throw any sudden or great amount of extra work upon it. Nevertheless, it is perfectly evident that if any fair amount of normal renal tissue were present in the disabled organ it should be preserved, so that if the obstruction could be removed it might again contribute to the needs of the organism. After exposing the kidney, it was incised with a view to this, but the external renal tissue was hard, firm, and extremely dark in colour for a few lines, then a cavity containing broken-down tissue mixed with blood was found, and lastly the enormously dilated pelvis. Drainage here would mean the slow contraction of a large cavity, lined by epithelium and kept from closing by a mass of useless tissue, which could only break down and come away later. I am not aware of any observations which show that renal tissue compressed to such an extent ever reserves itself sufficiently to be able to resume its functions. Microscopically, this tissue showed atrophied and more or less empty tubules, whilst the Malpighian tufts were extremely small and their epithelium indistinguishable. Under these circumstances it seemed best to relieve the patient at once of the entire organ and to leave only a clear space, the raw surfaces of which might be expected to rapidly unite. When the whole kidney was removed, a small lobule the size of a hazelnut, at the lower extremity of the kidney, was found to be still healthy.

Medical Societies.

PATHOLOGICAL SOCIETY OF LONDON.

Malignant Disease of Fallopian Tube.—Cystic Disease of Testis.—Congenital Heart Disease in Adult.—Cancer of Brain.—Cancer of Liver.—Stenosis of Coronary Arteries.—Mammæ in Dermoid Cysts.

AN ordinary meeting of this Society was held on May 1st, Dr. J. Hughlings Jackson, F.R.S., Vice-President, in the chair.

Mr. ALBAN DORAN brought forward a case of Malignant Disease of the Right Fallopian Tube and Ovary. The tube was dropsical, and its walls were invaded by a cancerous growth. The ovary was small, but completely converted into new growth. The patient was a married woman, aged forty-eight. For three years she had been subject to a clear vaginal discharge, which sometimes contained membranous fragments. In January, 1887, Dr. Amand Routh scraped out the interior of the uterus, removing a quantity of red fungous growth. An attack of pelvic inflammation followed, and during the patient's recovery a tumour was detected rising to the right above the pubes. The tumour grew slowly larger, and the patient lost flesh; fragments of solid matter came away in the discharge. On March 1st, 1888, Mr. Knowsley Thornton removed the tube and ovary; the patient recovered. The uterus was free from malignant disease. A series of sections of the new growth were also exhibited. The tumour substance was made up of collections of large polymorphous cells, surrounded by trabeculæ, which were infiltrated with small cells. A few tubules lined with ciliated epithelium were to be seen; they were surrounded by a wide area of large flat cells. The tubules and their surroundings suggested the glands which, as Hennig and Bland Sutton have demonstrated, exist in the Fallopian tube, and further indicated that the cancer originated in those glands. The same collections of large cells (with wide oval spaces caused by vacuolation) and trabeculæ, showing small cell infiltration, were to be seen in sections from the ovary. The history of the case and the small size of the infected ovary compared with the large proportions of the growths in the tube would appear to prove that the tube was the primary seat of cancer. A cancerous ovary grew very rapidly, and seldom infected the tube till it had become a large tumour. Only three cases of primary malignant disease of the tube had been described. The first (Scanzoni's) was doubtful; in the second (Dr. Senger's of Breslau) the tumour was sarcomatous; the third occurred in Dr. Martin's practice, and was described by Dr. Orthmann as an instance of truly cancerous papilloma. In the specimen exhibited by Mr. Doran, malignant degeneration of previously innocent papillomatous growths might have taken place; but in any case he believed that the cancer was histologically of glandular origin.

Mr. QUARRY SILCOCK showed a specimen of cystic disease of the testis. The body of the testis was the seat of an interstitial fibroid overgrowth, apparently radiating from the mediastinum testis, with an accompanying progressive cystic dilatation of the seminiferous tubules. The cysts, to the naked eye, varied in size from a pin's head to a pigeon's egg, but microscopically every stage between a well-formed seminiferous tubule and the fully developed cyst was observable. A scrotal tumour was thus formed, which consisted almost wholly of tough-walled cysts, some of these having ruptured, apparently owing to the absorption of the intermediate fibrous tissue, so giving rise to multilocular cystic cavities of considerable size. The cystic contents varied, being a clear hydrocele-like fluid in the larger cysts, or a thick glairy fluid or caseous material in the smaller. The specimen was removed from the body of a middle-aged man who died in the medical wards of St. Mary's Hospital, so that there was no history attached to it. The disease appeared to be analogous to some cases of cystic disease of the breast with general dilatation of the ducts, and to pure cystic dilatation of the kidney. There was no evidence to the naked eye, or microscopically, to show that it was connected with the formation of a neoplasm, such as an adenoma or fibroma. The vas deferens appeared to be permeable and healthy. The vesiculæ seminales were not examined.

Dr. H. MONTAGUE MURRAY showed a specimen of a Patent Ductus Arteriosus in a woman who died, aged thirty-six, of malignant endocarditis. During life there was a systolic thrill over the pulmonary cartilage and a systolic bruit, loudest at the same place. The patient died with the ordinary signs of ulcerative endocarditis. She had never been cyanosed, nor had she clubbing of the finger ends. At the post-mortem the heart weighed 18 oz., the hypertrophy being chiefly on the left side, and vegetations were found on all the valves. The ductus arteriosus was patent, about three-eighths of an inch in length, and large enough to admit a quill. A large mass of vegetations was found near the opening of the duct in the pulmonary artery. This condition occurring in an adult was rare. The position of the vegetations, the dilatation of the pulmonary artery, the absence of cyanosis, and the position of the murmur and thrill seemed to show that blood passed from the aorta into the pulmonary artery; while the absence of any marked hypertrophy of the right ventricle was evidence that there could have been but little obstruction caused in the pulmonary artery by the entrance of blood.

Dr. MURRAY likewise showed a case in which the aorta arose from both ventricles, the inter-ventricular septum being incompleted, there being also stenosis of the pulmonary artery. The patient was well up to twenty-one years of age, when she had an attack of rheumatism and possibly heart disease. This was followed by attacks of cardiac failure, with persistent cyanosis, phthisis, and finally tubercular meningitis. There was a systolic thrill at the apex, a systolic

murmur heard both at apex and base, and the pulmonary and aortic cartilages, traceable along the great vessels and round to the angle of the scapula. A diastolic murmur was heard a year before death. At the post-mortem, vegetations were found on all the valves, a large aorta arose from both ventricles, and the inter-ventricular septum was deficient at its upper part. The infundibulum was small and the pulmonary valves adherent, so that an opening only a quarter of an inch in diameter existed. The ventricular walls were of equal thickness. There were cavities at the apices of both lungs and grey granulations scattered through them, and the usual signs of tubercular meningitis. Attention was called to the age of the patient, to the absence of cyanosis for twenty-one years, and to the probable origin of the pulmonary stenosis as being partly congenital and partly acquired, and lastly to the occurrence of tuberculosis in the course of congenital heart disease.—Dr. S. H. HABERSHON referred to a case he was showing as a card specimen, in which only one vessel arose from the heart, from a hypertrophied right ventricle; a small fibrous cord was found to represent the pulmonary artery. From the aorta there sprung a ductus arteriosus which supplied the lungs by a right and left pulmonary branch. The right auriculo-ventricular valve had but two cusps, and there was a perforation at the undefended spot. A horseshoe kidney was found in the same specimen. The child lived to the age of four years.

Dr. JOSEPH COATS showed a specimen of Multiple Cancer of the Lungs, Bones, Brain, &c. There was an old cavity with cancerous walls in the right lung, and there were numerous secondary tumours both in this lung and in the other. The cavity with cancerous walls was regarded as a primary ulcerating cancer of the lung. There were secondary tumours in the bones, liver, pancreas, and kidneys. The most extraordinary condition, however, was that in the brain. Here there were cysts of various sizes, numbering no less than twenty-four, the largest about two inches in diameter and the smallest about a quarter of an inch. There was only one instance of a consistent tumour in the brain, and even this was soft and evidently to a large extent cystic. Microscopic examination showed in the lung tumours a typically cancerous structure. The tumour which was regarded as the primary one showed alveoli resembling in size and shape the normal lung alveoli, but occupied by epithelial cells, the peripheral ones of which had a regular cylindrical shape. In the secondary tumours in the lung the alveoli were less regular in size and shape, and they showed a tendency to cystic development, apparently by colloid metamorphosis of the cells. In the bones, it was found that the expanded ends of the femur were largely occupied by cysts in various stages of development, from simple collections of epithelium to large spaces filled with colloid material. The bone was greatly atrophied, being only represented by narrow trabeculæ. In the brain the cysts had a definite lining of epithelium. In the case of the semi-solid tumour, cysts in various stages of development were visible, much resembling those in the bone. Dr. Coats regarded the tumour in the lung as the primary growth, chiefly because of its size and apparent age, and also because there was cancerous infiltration of the bronchial glands, these alone of all the glands in the body being affected. It was regarded as very extraordinary that in the bones and in the brain the secondary tumours should have shown this extraordinary cystic character. The clinical history of the case was given from notes by Professor Gairdner. P. H——, aged seventeen, was affected with various nervous symptoms, of which the chief were amaurosis, squinting, and nystagmus, but without any definite paralysis or loss of intelligence. In the course of the disease tumours in the bones were observed. The case ended with convulsions.

Dr. JOSEPH COATS also showed an example of Primary Cancer of the Brain. The tumour was oval in shape, and measured about an inch and a half in diameter. It was situated above the pons and peduncles, apparently growing in the aqueduct of Sylvius, distending it and projecting into the fourth ventricle. The anterior part of the aqueduct was unaffected and the third ventricle normal. Under the microscope the principal constituents were cylindrical epithelium cells arranged in rows and enclosing spaces. Dr. Coats suggested the origin of the tumour from the epithelium of the aqueduct. The clinical history supplied by Professor Gairdner showed the principal symptoms to have been "weak turns," pain in the head, vomiting, and retraction of the head. She gradually became very lethargic, and was difficult to arouse. She underwent progressive emaciation up till death.

Dr. CROOKE (Birmingham) exhibited Specimens from a case of Primary Growth of the Liver. The patient was a printer, aged sixty-five, who had been under the care of Sir Walter Foster and Dr. Simon. The liver when the patient came under treatment was uniformly enlarged; there was some ascites and distinct jaundice. After systematic examination a diagnosis of primary cancer of the liver was made. At the necropsy this diagnosis was confirmed, no other organ or part of the body being affected. The liver, which was uniformly enlarged, weighed 104 oz.; its general shape was unaltered, but its entire surface was covered with round nodules. On section the growth was diffused in the central part of the right lobe, the general colour being greyish-white, but streaked by lines of fatty degeneration. Throughout the whole of the left and the extremity of the right lobe there was discrete nodular infiltration. A microscopical examination of the growth revealed appearances which illustrated the mode of origin of primary growths of the liver—namely, from proliferation of liver cells. Groups of cells were to be met with in the advancing part of the growth, which had very large nuclei, some of which might be observed to be dividing; in other parts a more active division of nuclei was seen, and the various stages of karyokinesis. With this nuclear division vacuolation and even division of the liver cells themselves occurred, and thus at the margin of the small nodules of growth columns of liver cells were formed, in which both processes were going on. The bridges between the vacuoles finally became absorbed, while the nuclei became arranged at the periphery; in this way a column of liver cells was converted into a tubule, lined by a highly nucleated protoplasmic border, or even filled with proliferating epithelioid cells; a tubule thus formed sprouted in all directions, the nuclei at the same time rapidly proliferating, and thus the typical structure was obtained. The stroma of the growth was, Dr. Crooke believed, derived from the peri-lobular and inter-cellular connective tissue. Well-defined bloodvessels were present only on the larger nodules, involving several lobules where Glisson's capsule entered considerably into the formation of the stroma. He thought it possible that cancer of the liver could arise in two ways from the bile ducts as usually described, and also from the liver cells themselves. Some excellent drawings accompanied the specimens.—Dr. COATS said that Dr. Crooke seemed to have departed from the old view that secondary growths originated from the proliferation of grafts derived from the primary tumour, and he accounted for the origin of secondary deposits by multiplication of the hepatic cells *in situ*, some specific agency being transferred from the primary growth and starting them into activity.

Dr. CHARLEWOOD TURNER showed a case of Extreme Contraction of the Orifices of the Coronary Arteries. The heart was from a man, aged fifty-two, who had been found dying in the yard where he had been at work. The cause of death had been extreme contraction of the orifices of the coronary arteries from atheroma of the commencement of the aorta. The left ventricle was somewhat hypertrophied, the muscle firm and of healthy appearance. Referring to similar specimens previously shown to the Society, and to other cases in which a similar lesion had been the cause of sudden death in cases of angina pectoris, he argued that stenosis of the coronary arteries caused death in all cases by interference with the blood supply of the myocardium, and not indirectly through interference with the nutrition of the nerves, as had been suggested by Dr. Dickinson. He would regard the pain and anxiety of the anginous attack as tending to the recovery of the sufferer by arresting all movement, and thus aiding a restoration of nutritive equilibrium in the heart wall.

Mr. BLAND SUTTON showed specimens of Mammæ in Dermoid Cysts. He said it was by no means uncommon to find in the interior of an ovarian dermoid tags of skin resembling a nipple. Such tags of skin might be associated with a more or less rounded projection, recalling in a striking manner the shrunken mammæ of a woman who has suckled many children. The surfaces of such mammæ occurring in ovarian dermoids were dotted over with numerous small pits indicating the orifices of sebaceous glands, and a crop of hair usually sprouted from the skin-covered surface. This condition was well illustrated by a specimen preserved in the museum of the Royal College of Surgeons. Standing beside it in the same collection was

another ovarian dermoid, presenting a mammæ of the size of a walnut, furnished with a nipple growing from its wall. Its surface was covered with dark-coloured, fine hairs; it was made up of fat covered with skin, containing sebaceous and sudoriparous glands. In the museum of the Middlesex Hospital an ovarian dermoid was preserved which had long excited his curiosity. The cyst was of the size of an orange, and standing from its wall was a mass of fat, covered with skin and furnished with a nipple. The mamma was supported upon a piece of skin-covered bone, lodging three teeth. On section, the interior of the mamma was seen to be occupied by a series of ducts, leading to a glandular mass at its base. This specimen had been for very many years in a preservative mixture, of which he did not know the composition, and which had not preserved satisfactorily the histological features of the tissue. Among a number of recent ovarian dermoids which he had received from various operators was one removed by Dr. Bantock. On examining it, he found the cyst contained a mamma, with a nipple passing from each side to join the cyst wall. The mamma was of the size of a Tangerine orange and composed chiefly of fat: lying in the midst of this fat was a series of tubules, leading to a glandular mass at the base of the mamma; above, these tubules passed directly into the nipples. When recent, the nipples were widely distended with fluid resembling very poor milk, but rather viscid. Under the microscope this fluid had all the characters of milk, and cells resembling colostrum corpuscles were present. The microscopical characters of the glandular tissue resembled that of the normal mamma in the arrangement of the ducts and acini, but differed from it in lacking the regular layer of cubical epithelium which lined the acini. These observations were of interest in the support they afforded to the view that mammæ were modified sebaceous glands.

The following card specimens were shown:—

Dr. CROOKE: Perihepatitis, with Cirrhosis of Liver.

Dr. H. HABERSHON: Malformation of Heart and Kidney.

Mr. DUNN: Cerebral Tumour.

Mr. SHATTOCK: (1) Cyst in Corpus Luteum; (2) Two Specimens of Hammer-toe.

Mr. LUNN: Pemphigus of Larynx.

Mr. MANSELL MOULLIN: (1) Osteoma of Skin; (2) Bladder with Vesical and Prostatic Calculi.

Mr. J. H. MORGAN: Ulceration of Bladder.

Dr. G. N. PITT: (1) Imperforate Anus; (2) Lymphadenoma of Stomach and Intestine.

CLINICAL SOCIETY OF LONDON.

Incision, with Drainage of Joints.—Perihepatitis.—Ovarian Tumours and Precocious Puberty.

AN ordinary meeting of this Society took place on the 27th ult., Sir Wm MacCormac, Vice-President, in the chair.

Mr. WAINWRIGHT read a case illustrating the Advantage of Early Incision with Drainage as opposed to Excision of Joints. The patient a boy aged three, was admitted to the West London Hospital about two years ago with a large abscess superficial to the periosteum, covering almost the whole of the outer aspect of the left thigh, which was said to have resulted from a fall a fortnight previously. This was treated by antiseptic incision and drainage. A fortnight later, before the incision was quite healed, the right hip began to inflame, and at the end of another month, distinct fluctuation being detected in four of his joints, it was incised and a quantity of pus evacuated. Carious bone was then found in the anterior part of the neck of the femur, which was removed by scraping, the joints being otherwise healthy. An antiseptic dressing was appiied, and the wound healed in another month, leaving a perfectly movable joint. Meanwhile, some thickening, which had existed about the left knee from the commencement, became more pronounced, and that joint became tender and painful; so that, shortly after the right hip had healed, the left knee was freely incised, and the cartilaginous surfaces freed from an overgrowth of synovial membrane, by which they were completely covered, by means of a sharp spoon and scissors. Antiseptic dressing and drainage were used, and the child left the hospital about six weeks later with a plaster splint on the left knee, the wound having healed. He was admitted about seven months later, and a small exfoliation of bone was removed from a granulation cavity just about the left knee. The sinus then healed, but the knee had become partially flexed, from the splint having been removed by the parents against orders. An effort has been made to correct this by extension and another plaster splint, but considerable deformity still exists. The knee is nearly immovable, but all the movements of the right hip are perfect.—Mr. BENNETT said it would be interesting if Mr. Wainwright could say where the scales came from which he described as having been removed from the side of the knee. He thought it was a sort of case by no means rare. The abscess described was such a one as followed inflammation due to injury. In such case the suppuration in the right hip while the child was lying quiet might be explained on the ground of pyæmia. This was a matter of some importance. He expressed himself as misled by the title of the paper, seeing that the operation performed on the knee joint merited something more than being called drainage. On the whole, he questioned whether the condition of the joint which had been described was better than would have followed excision. He asked what was the condition as regarded locomotion.—Mr. LUCAS mentioned a case in which three joints had been affected in succession, requiring excision. He thought that so far as the hip was concerned he would agree with what Mr. Wainwright had advocated—viz., incision, examination, and removal of any carious bone in the neighbourhood. Excision as at present practised was a very different operation to what it used to be. He always clipped away the synovial membrane all round before proceeding to remove the bone.—Mr. HOWARD MARSH thought the paper turned on the question as to whether the disease of the joint was tubercular or pyæmic. He has often seen good results follow Mr. Wainwright's treatment in pyæmic abscesses, but he doubted whether this would be the case in tubercular disease. He thought excision was destined to become more rare than heretofore. He himself had been very disappointed with the results obtained from excision of the hip.—Mr. PARKER hoped that the possibly misleading title would not be allowed to detract from the excellent results of the treatment carried out.—Mr. BENNETT asked whether Mr. Parker considered multiple abscess evidence of tubercular disease.—Mr. PARKER said they did not absolutely prove the existence of tubercular disease, but if a child had disease of the knee, and then polypoid disease of the hip, the evidence was in favour of struma.—Mr. SYMONDS said he had examined the child and thought it was a brilliant result. At the same time, he was not sure that the child was suffering from tubercular disease. He suggested that the hip disease was due to extension upwards. His own experience was decidedly in favour of the operation. There were, however, a number of cases in which excision was the only operation.—Sir WILLIAM MAC CORMAC said the knee was evidently the seat of strumous synovitis which had been erased with arthrectomy.—Mr. WAINWRIGHT, in reply, said the bone he removed from the thigh was not carious. The child's temperature never rose above 100°, and was generally normal, which he thought was inconsistent with pyæmia. He did not erase the hip in any case, and did nothing to the synovial membrane or the cartilage.

Dr. HALE WHITE read a paper on Perihepatitis. He began by giving an account of a man aged twenty-nine, in whom the abdomen had been tapped thirty-five times for ascites, and from whom 790 pints of clear fluid had been drawn off. The tappings extended over a period of about twenty months, and at times the fluid re-collected at the rate of two pints a day. On one occasion thirty-one pints and a half were drawn off at one time. The patient had been abroad a great deal, and had had ague, dysentery, rheumatic fever, typhoid, and probably syphilis. He gradually sank from diarrhœa, and at the necropsy it was found that he had general lardaceous disease, granular kidneys, and universal perihepatitis, perisplenitis, and chronic peritonitis. There was never any jaundice, nor was there any evidence of dilatation of the portal vein. For these reasons, and because of the extreme rapidity with which the fluid re-collected, Dr. Hale White maintained that neither pressure on the whole liver nor on the portal vein could explain the ascites. He examined forty cases in the Guy's Records, of which twenty-two were cases of universal and eighteen of partial perihepatitis; of the latter, six were examples of malignant or tubercular peritonitis. The conclusions to which he arrived were that universal perihepatitis is in the great majority of cases part of a general disease consisting of chronic peritonitis and universal capsulitis of spleen and liver. It is almost invariably associated with granular kidneys, and frequently with gout, syphilis, over-indulging in

alcohol, or diseases of the heart or lungs causing backward pressure. The cause of the ascites is the general chronic peritonitis, for there is no ascites in the very rare cases in which chronic peritonitis is absent. There was never any evidence that the disease could remain latent, or that it tended to recover, so that the prognosis is bad. The cases of partial, are probably distinct from those of universal, perihepatitis. In the former the thick capsule will not peel off, there is no folding of the anterior edge, the capsulitis of the spleen is not universal, and there is but rarely any peritonitis or ascites. It appeared probable that the universal perihepatitis began equally all over the liver, and that the partial was never converted into the universal form. The average age at death of cases of universal perihepatitis was forty-seven years and a half, the oldest being sixty, the youngest twenty-nine. There were thirteen males to eight females. It was suggested that if the author's contention—that universal perihepatitis was only part of more general disease—turned out to be correct, it would be better to have a new name for that disease.—Dr. KINGSTON FOWLER said he had very frequently demonstrated the presence of these membranes on the surface of the liver in cases of ascites of long standing. The same thing was found on the peritoneum elsewhere. He attributed the membrane in some cases to the peritonitis set up by repeated tapping. A very similar condition was seen in the pleural cavity when dropsical fluid had been long present.—Dr. SIDNEY PHILLIPS said he had often remarked how very rapidly the abdomen refilled after tapping in cases of perihepatitis. He said that several varieties had been described, and designated three which occurred. He mentioned the case of a man under his care who had jaundice a long time without ascites, but in whom the ascites was very acute a month before death. He agreed in discarding the theory that the liver was compressed by the membrane.—Dr. LONGHURST inquired how far the condition described might be due to climatic influences, and asked where the patient was when the disease first showed itself.—Mr. LUCAS quoted two cases. In the first the abdomen rapidly filled up after repeated tappings. The patient was a youth with a peculiarly blue complexion, and he diagnosed pericarditis with perihepatitis. In that case there was an inguinal hernia, and they had attempted to drain the peritoneum through the patent canal. This proved unsuccessful in consequence of the blocking of the tube and the closure of the opening by lymph. The diagnosis was confirmed at the post-mortem, and the membrane was also found binding down the lungs. In the second case he made an oblique incision through the linea alba for the purpose of drainage, and it succeeded admirably.—Mr. SYMONDS quoted an unsuccessful attempt to drain the peritoneum. He said that they could not wipe over the peritoneum with pure carbolic acid, and nothing short of that would be of use.—Dr. HALE WHITE, in reply, said there might be a general cause at work, but what it was could not be made out. Climatic influence could not be traced.

Mr. R. CLEMENT LUCAS read a paper on a case of Tumour of the Right Ovary in a child of seven, associated with Precocious Puberty. The patient was admitted into the Evelina Hospital in December, 1884, for a tumour of the abdomen, and the mother had noticed some time before that the child at times had a dark blood-stained vaginal discharge. Other signs of puberty were also present—viz., firm breasts as large as oranges, and a mons veneris covered with hair an inch in length. The tumour was firm and slightly lobulated. This extended from the right iliac region to within two fingers' breadth of the left anterior superior spine, and from the pubes upwards to one inch above the umbilicus. The child menstruated whilst under observation on the 7th, and again on the 25th of January, 1885. Mr. Lucas performed ovariotomy on Feb. 4th, 1885. The tumour was a solid round-celled sarcoma. The child menstruated again on Feb. 6th, two days after the operation, but from this time it ceased. The signs of puberty also gradually receded, the breasts again becoming flat. The child made an excellent recovery, and when seen two years and nine months after the operation was in perfect health, and showed no signs of recurrence.—Mr. HOWARD MARSH said it was not so in all instances, that growing ovarian tumours in children hastened the advent of puberty. Some years ago he performed ovariotomy on a child of eight in whom no precocity existed. He thought that point might be settled by looking up the records of such cases, which were not rare.—Mr. MERREDITH mentioned a case to prove that these tumours were not always accompanied by sexual precocity. The patient was a little girl of seven, from whom he had removed a sarcomatous growth of the ovary. On the other hand, the stimulating effects of ovarian growths on the sexual functions were well marked when they occurred in women after the menopause.—Dr. ANGEL MONEY said that negative evidence went for nothing in such cases. He mentioned a case of sarcomatous growth of the supra-renal body in a little girl of three who exhibited many signs of sexual precocity. A similar case had also been recorded by Dr. Dickinson.—Mr. HOWARD MARSH said that it would be interesting to collect a number of cases of precocious puberty, of which he had seen a large number.—Mr. BENNETT asked whether any of the members of the family had exhibited similar precocity?—Sir WM. MCCORMAC approved of Mr. Marsh's suggestion, and thought the case pointed to some such association as that indicated.—Mr. WILBERFORCE SMITH asked whether the subsidence of the mammæ had persisted.—Mr. LUCAS, in reply, said that the mammæ had remained small. There was no history of any similar precocity in the other members of the family.

MEDICAL SOCIETY OF LONDON.

Eclampsia Rotans.—Eclampsia Nutans.—Post-mediastinal Sarcoma.—Radical Cure of Lumbar Hernia.—Osteoplastic Resection of Foot.—Functional Contraction of Hand.—Obstructive Jaundice.—Kyphosis.—Papillomata of Larynx.

THE last ordinary meeting of this Society, held on the 30th of April, was a clinical evening. The President, Sir William Mac Cormac, occupied the chair.

Dr. W. B. HADDEN brought forward a case of Eclampsia Rotans in a child aged ten months. It had exhibited symptoms for two months; there was a history of head-injury, and three children in the same family had suffered from convulsions. The head was moved from side to side, and at times there was lateral nystagmus. Dr. Hadden also exhibited a child with vertical nystagmus of the left eye coming on a week after a fall on the head; and he referred to a case of eclampsia nutans in a child aged nine months, who shortly after birth used to throw her head backwards and look through her half-closed eyes. About six months ago the eyes began to rotate, and very soon afterwards the head movements were noticed. Two or three times daily she appeared to lose consciousness; the nodding of the head was especially noticed when the child was interested in anything. There was constant vertical nystagmus, which went on independently of the head movements, and which had a different rate of movement, being much more rapid; the eyelids also shared in the ocular movements, and were affected synchronously.—Dr. OUTTERSON WOOD inquired if there were any injury to the cranium at birth.—Dr. HERRINGHAM compared the cases shown with those of paralysis agitans occurring at the opposite extreme of life.—Dr. HADDEN could get no history of unusual presentation or injury at birth. He thought the whole of these cases should be termed nystagmus.

Dr. HERON exhibited a case which was probably Sarcoma of the Posterior Mediastinum, occurring in a bottler aged fifty. He had been quite well for fourteen years before last Christmas, and complained at first of pain, which was constant, and extended from the right clavicle to the level of the tenth rib in front and between points behind corresponding to those two situations. During the last four months he had vomited all solid food, and he described this part of his case by saying that he felt the food stick at the pit of his stomach, and then within five minutes he vomited, rejecting all the solid food. The vomiting was preceded by nausea, but never accompanied by blood, nor had any been passed per anum. He took liquid foods with comfort and enjoyed them, his appetite being excellent. His bowels acted well with the help of an occasional pill; the kidneys and urine seemed healthy. He had been losing flesh for about two months or more. The visible veins of the arm, neck, and chest were enlarged on the right side. The right infra-clavicular region was markedly more prominent than the left, though no physical cause for it could be detected; there were in this prominent region one or two enlarged glands, isolated and not tender to the touch; the axillary glands were not enlarged. In the groins were

colonies of enlarged glands, not tender, and containing towards their middle one or two distinctly larger than the others. The submaxillary glands were enlarged, and at the back of the neck one could also be felt bigger than normal. The right eyelid drooped slightly yet distinctly, but was not otherwise crippled in its actions. The right pupil was contracted, the left, perhaps, being larger than normal. The motions of the right pupil were markedly sluggish, but it distinctly, though slightly, responded to light and accommodation. The actions of the right eyeball were perfect, but examination of the vision revealed slight loss of definition, though the fundus oculi appeared healthy. The voice was hoarse, and on examination the right vocal cord was seen fixed and rigid; the laryngeal mucous membrane was congested. There was dulness on percussion, not marked, but distinct, on the right side of the chest, in front and behind, over an area measuring two inches and a half in depth at its outermost boundary close to the humeral head, and one inch and a half at its inner boundary to the right of the middle of the manubrium sterni, the percussion note elsewhere being abnormally hyper-resonant. On auscultation wheezing and snoring râles were heard, and over the dull space at the pulmonary apex vocal fremitus and resonance were increased. Arterial pulsation was equal wherever it could be tested, and there was no abnormal pulsation at any point. There was a trivial cough, and no history of syphilis or strain could be elicited. There was no cardiac murmur and no thrill on palpation. He had been treated by twenty-grain doses of iodide of potassium.—Mr. JESSETT thought the rapid impediment to the circulation was in favour of sarcoma.—Dr. SEYMOUR TAYLOR related a somewhat similar case where a mediastinal growth pressed upon the superior vena cava.—Mr. ADAMS FROST thought the ocular symptoms indicated lesion of the sympathetic.—Dr. BREVOR suspected that pressure was exerted near the origin of the second dorsal nerve, as it had been shown that the dilator fibres of the iris came off at that point.—Dr. HERON said there was a strong suspicion that the drooping of the eyelid was of old standing. Nitro-glycerine had been given without success, and the iodide so far had done no good.

Mr. EDMUND OWEN showed a girl of five years and a half who had been under his care at the Great Ormond-street Hospital for a Lumbar Hernia, which had followed the track of an extinct spinal abscess. A year and a half previously the child had fallen down six steps, and some months afterwards she had had pains in her back and in her foot. In due course an abscess formed over the left iliac crest; it broke when she was away in the country, and it kept on discharging for three months. Some time after the abscess wound had healed a lump again appeared over the iliac crest; it was naturally thought to be an abscess, and for its treatment the little patient was sent (in November last) to the Children's Hospital, where Mr. Owen saw her for the first time. Her back was straight and stiff, and there was a slight abnormal projection of some of the lumbar spines. There was a rounded, reducible tumour, about the size of an orange, over the left iliac crest, the skin over its central spot showing a firm white cicatrix. The tumour was resonant on percussion, and probably contained a portion of the sigmoid flexure of the colon, some hardish nodules in the interior suggesting fæces. On returning the contents of the tumour the finger could be thrust through an abdominal opening, which evidently occupied the site of the gap between the anterior border of the latissimus dorsi and the posterior border of the external oblique—the triangle of Petit. After the child had been some weeks in the hospital, a vertical incision was made over the tumour, until what was supposed to be the region of the transversalis fascia was reached; the contents of the tumour were then reduced, and the pillars of the lumbar opening were approximated by three strong catgut sutures. The case did well; there had since been no return of the hernia, though there was still some weakness in the region of the small triangular space. Though lumbar herniæ had on certain occasions been operated on as chronic abscesses, or had been dealt with as lipomata, and though cases were on record in which herniotomy had been performed with success, in which the bowel had become strangulated through the triangle of Petit, this was possibly the first occasion on which the radical cure had been performed for a reducible lumbar hernia.

Sir WILLIAM MAC CORMAC then showed a lad on whom he had performed Osteo-plastic Resection of the Left Foot by the method of Mikulicz. The paper in which the case and operation are described is printed in full in another column.—Mr. BERNARD PITTS thought the result satisfactory both as to progression and appearance.—Mr. JESSETT related a case in which he had gouged away the astragalus and os calcis, and obtained ultimately a good result.—Sir WILLIAM MAC CORMAC said the limb operated on was now one inch longer than its fellow.

Dr. BREVOR showed a case of Functional Contracture of the Right Hand in a boy aged fifteen, who last May had an injury to the right wrist from a lift, which bruised but did not break the skin. He was insensible for a few minutes, but could use the right hand fairly well till five days after, when it began to get stiff, and the next day the flexors contracted and the hand had remained closed ever since. A week after the injury the right hand became numb, and the loss of feeling gradually spread up the arm, in a few days reaching the shoulder. At present the right hand was closed, and never relaxed even in sleep, but he had good movement in the other joints of the limb. There was complete anæsthesia, analgesia, and loss of muscular sense in the right upper extremity as far as the shoulder, where it suddenly ceased. The case was analogous to those of contracture and anæsthesia produced by Charcot in hypnotised girls.—Sir WILLIAM MAC CORMAC referred to a case under Charcot's care of anæsthesia of both deep and superficial structures following an injury; the line of anæsthesia was very abrupt.—Dr. HADDEN said that Charcot had pointed out that in many hysterical affections following an injury there was a previous history of some hysterical symptoms.

Dr. HERRINGHAM showed a case of Obstructive Jaundice with enlarged Gall-bladder, occurring in a man of sixty-eight, who was seized with violent pains in the abdomen with rigors in the middle of March. Ten days later he developed jaundice. When seen there was deep jaundice; the liver was an inch and a half below the ribs at the nipple line, and the gall-bladder could be felt as a rounded tumour projecting down to the umbilicus. The liver was tender on palpation, the gall-bladder felt elastic, and there was an indistinct crepitation suggesting gall-stones when it was pressed. No stones had been passed since he came under treatment. The principal complaint was of intense itching, preventing sleep. The diagnosis was obstruction of the bile duct by a gall-stone. The treatment consisted of opium pills to relieve attacks of pain, a draught of tartrate of soda internally, and lotions, none of which proved of great benefit, for the itching.

Dr. HERRINGHAM also exhibited a boy aged seventeen, much affected with rheumatism, and possessing a systolic cardiac murmur, whose back presented a long kyphotic curve, beginning about the tenth dorsal, and ending at the third lumbar vertebra. The boy maintained that he had had it ever since he could remember, but his history was probably not very trustworthy as to that; though it was certain it had existed for two years, and before that he had for three years to carry two heavy milk-cans. The case was shown for diagnosis. Dr. Herringham thought the choice lay between rheumatic arthritis and kyphosis from the pressure of the weight; he was inclined to the latter view.

Mr. BOWREMAN JESSETT showed a case which came under his care at the Cancer Hospital three years ago. The patient had previously been an inmate of Middlesex Hospital, where, Mr. Leopold Hudson informed him, tracheotomy was performed on him five years since by Mr. Hulke for syphilitic laryngitis. The man was suffering when first under Mr. Jessett's care from total inability to speak above a whisper, and he could not breathe when the tracheotomy opening was stopped up. On removing the tube, the larynx and the trachea above the level of the tube were seen to be blocked with a quantity of papillomatous growth. With the laryngoscope the vocal cords were seen to be thickened, and, the papillomata had extended upwards. The whole surface was painted over with a 20 per cent. solution of cocaine, and, the tube being removed, the growths were scraped away with a sharp scoop introduced through the tracheotomy opening. It was followed by a good deal of bleeding, the blood being expelled by violent coughing. The man made a good recovery, and has had no return of the growth since, going about with a cork in the tube, and being able to talk well. Mr. Jessett had not thought it desirable to close the tracheal opening, as it caused no inconvenience to the patient, and should the laryngeal growth recur it might be difficult to re-open the trachea.—Mr. PITTS inquired if tubage had been tried to dilate the stenosed larynx.—Mr. JESSETT replied in the negative.

HARVEIAN SOCIETY.

Alopecia Areata.—Ovarian Tumours.—Venesection.

A MEETING of this Society was held on April 19th, Dr. Sedgwick, President, in the chair.

Dr. ROBINSON read a paper on Alopecia Areata. He described two varieties: a parasitic and a non-parasitic. The former had a relationship to ringworm. He had found life in the open air one of the most efficacious modes of treatment.—Dr. LYLE had not seen alopecia follow ringworm.

Dr. BRAXTON HICKS, F.R.S., then related two cases of Ovarian Tumour associated with Pregnancy, in which the removal of the tumour had been followed by recovery. In the first case labour had continued thirty hours. The tumour came down, and prevented the head being seized with forceps, and turning was tried, but found impossible. The child was finally delivered with long forceps, and is still living. The placenta required removal. The tumour grew rapidly after delivery, and was removed. It was adherent everywhere, and was very compound in character, nearly colloid. The patient made an excellent recovery. In the second case there was an ovarian tumour which reached rather above the umbilicus. It was diagnosed to be composed of two cysts. The woman had missed two periods, and it was proposed to wait until after the middle of pregnancy. However, the cyst became tense with pain, and was removed. The pedicle was found twisted, and the tumour adherent and becoming necrosed. No uterine action came on for two weeks, when an ovum was expelled. The cases showed that when ovarian tumour and pregnancy were concurrent, if the tumour gave signs of irritation, the sooner it was removed the better.—Dr. HANDFIELD JONES spoke of the rapid growth of ovarian cysts after the uterus had been emptied. He had known them within two months attain enormous size and contract adhesions. He thought, therefore, that ovarian tumours ought to be removed as soon as possible after delivery.

Dr. FRANKISH read a paper on Venesection. He had found it of particular benefit in cases of uræmia and cerebral congestion. He had seen puerperal convulsions in cases where there was albumen in the urine especially benefited by it. In spite of popular prejudices, he thought it ought often to be practised.—Dr. BRAXTON HICKS said venesection had been most beneficial in cases of puerperal convulsions.—Dr. SEDGWICK felt that popular opinion rendered venesection difficult to practise, although often beneficial. The older practitioners used to bleed in the early stages of collapse, especially when due to perforation. It was also practised in the collapse due to cholera.—Dr. HANDFIELD JONES mentioned a case in which he had bled for amenorrhœa with excellent results.—Dr. FRANKISH replied.

MIDLAND MEDICAL SOCIETY.

AN ordinary meeting was held on April 4th, 1888, Surgeon-Major Turton in the chair.

Senile Chorea.—Dr. SUCKLING showed a woman aged sixty-two who had suffered from chorea for nine years. No family history of importance could be obtained. The patient had suffered from chorea when twelve years of age, but she recovered completely from this attack in about three months. She had an attack of rheumatism when she was fifty-five. The jerky spontaneous movements affected both the upper and lower extremities, the tongue and lips being especially affected. There was considerable incoördination, and the disorderly movements were intensified by emotional disturbance and ceased during sleep. The intellect was unaffected; there was no sensory disturbance, and no sign of heart disease. The patient attributed her illness to worry and anxiety.

Drop Wrist and extensive Muscular Atrophy from Lead Poisoning.—Dr. SUCKLING also showed a young woman who had worked as a maker of paper bags four years ago, and who had to give up her work on account of paralysis of the extremities. She had suffered from colic and constipation. There was a well-marked blue line on the gums, and double wrist drop. The supinator longus on each side was much weakened. The thenar and hypothenar muscles on each side were wasted, and the *main en griffe* was present. The muscles of the forearms and shoulders were also much atrophied. The intrinsic muscles of the hands and the extensors of the wrists did not respond to the faradic current. Dr. Suckling pointed out the distinguishing features of the case from one of ordinary progressive muscular atrophy.

Lupus Vulgaris.—Dr. KIRBY showed a case of lupus vulgaris of seven years' duration in the arm of a girl fourteen years of age, from which she was recovering rapidly under treatment by Unna plaster. There was no history of struma in the family, but several relatives had died of cancer.

Pancreatic Cyst.—Mr. BENNETT MAY reported a case of pancreatic cyst, for which he had operated. The operation resulted in the removal of a large gall-stone from the gall-bladder. The cyst had collapsed previously to the operation, but two months before that a quart of fluid was removed by aspiration. The necropsy showed that death was caused by gangrene of the pancreas. The cyst had a large aperture of communication with the duodenum. It appeared probable that it was a retention cyst (gall-stone in common orifice), as there was a well-marked history of attacks of severe biliary colic with jaundice.

Mr. BENNETT MAY also showed a number of Vesical Calculi.

Mr. JORDAN LLOYD showed a case of Encysted Hydrocele of the Epididymis, and also a large Urethral Calculus that had been passed by a boy.

Dr. FOXWELL read a paper on the Davos and Engadine Valleys.

At the meeting on April 18th, Mr. Ross Jordan, President, occupied the chair.

Ataxia in a Brass-worker.—Dr. HOGBEN exhibited a case of ataxia occurring in a man thirty-one years of age, who was a brass-worker. The patient came to the out-patient room at the Queen's Hospital two years ago, complaining of tremors and weakness in the legs. He had the green discolouration of the teeth characteristic of his occupation. His gait was staggering, and he suffered much from static ataxia, being quite unable to walk in the dark or to stand with his eyes closed. On examination, his muscular sense was found to be much impaired in the lower extremities. There was no loss of sensation. The patellar tendon reflex was exaggerated, and ankle clonus was present. His pupils responded to light and accommodation, and the fundus oculi appeared healthy. He had not had syphilis, and there was no history of gastric or other crises. The patient had continued under observation for two years, without much progress for better or for worse.

Mr. LAWSON TAIT showed the following specimens:—A Sarcomatous Kidney, weighing 1 lb. 2 oz., removed from a child three years of age; a Dermoid Tumour of Ovary with a long twisted pedicle, and adherent to the ascending colon; a large Cystic Kidney removed from a woman aged fifty-two.

Mr. E. L. FREER showed a case of Dupuytren's Contraction in a man that he had successfully treated by multiple incisions.

Mr. FREER also read a paper on the Treatment of Curvature of the Spine, and demonstrated the mode of applying the divided plastic cuirass.

GLASGOW OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

THE seventh meeting of the session was held on April 25th, Mr. Stuart Nairn, Vice-President, in the chair. Mr. Rob-Jardine, M.B., C.M., was duly elected a Fellow.

Dr. PARK introduced a discussion on Trachelorraphy, in the course of which he criticised and traversed the views and conclusions of Noeggerath. He thought subinvolution and hypertrophy were not only directly but remotely sequent to lacerations of any considerable extent, but that while that was so, these frequently yielded to treatment, and trachelorraphy was only called for in intractable cases. The discussion which followed was an animated one, and taken part in by Drs. Sloan, Oliphant, Polfok, Turner, Stark, and Nairn.

OXFORD needs a public mortuary, and Mr. E. L. Hussey, the city coroner, has drawn the attention of the Local Board to the matter.

Reviews and Notices of Books.

Ophthalmic Surgery. By ROBERT BRUDENELL CARTER and WILLIAM ADAMS FROST. Illustrated with a Chromograph and 91 Engravings. Pp. 554. London: Cassell and Co. 1887.

THIS is a students' manual, dealing almost entirely with the purely practical side of the subject, and corresponding in size and the general arrangement with the well-known treatises of Lawson and Nettleship. The authors have so divided the volume that Mr. Carter takes the anatomy and physiology of the eye, and the mode in which its clinical examination should be conducted, together with diseases of the sclerotic and cornea, iris, lens, and retina; whilst Mr. Frost discusses the diseases of the eyelids, lacrymal apparatus, conjunctiva, vitreous humour, injuries of the eye, colour vision and its defects, errors of refraction, affections of the ocular muscles, and diseases of the orbit. As might be expected from the knowledge and experience of the authors, it is well written, and the defects of such a work consist rather in sins of omission than of commission. In speaking of cataract, Mr. Carter entertains no doubt of the general advantages of the practice of iridectomy, or of the desirableness of its being adhered to as a matter of ordinary routine. We should be inclined to object to this statement. With the immense assistance that cocaine affords, we hold that iridectomy is in a large number of cases of mature cataract in elderly people unnecessary. Everyone will allow that the less damage that is done to an eye in the operation for extraction the better, and that iridectomy does inflict considerable damage there can also be no doubt. The questions, which can only be settled by statistics, are whether needling is more frequently required in cases of extraction without, as compared with extraction with, iridectomy; and whether such needling succeeds better in the one case than in the other. Mr. Carter does not refer to an occasional but startling accident that is now and then, though rarely, observed after an iridectomy—namely, the sudden filling of the anterior chamber with blood, due to the rupture of some small vessel at the cut edge of the iris. As a rule, it disappears spontaneously. The details of the operation for extraction are given with great fulness and care. He uses the cocaine wafers to produce insensitiveness of the cornea. We think the fresh 4 per cent. solution is superior. The sections on refraction of the eye and the correction of errors of refraction by Mr. Frost are excellent, he having had much practice in their relief and in teaching students the principles on which they should be corrected. Mr. Frost discusses dislocation of the lens, and says very properly that when dislocation takes place into the anterior chamber it should be removed by operation, but he omits to say what should be done in the not unfrequent accident of partial dislocation. Supposing such a condition to excite irritation, should prolonged rest be prescribed? should an attempt be made to remove the lens? should an iredectomy be performed? should the eye be removed? These are questions that have arisen more than once in the experience of most ophthalmic surgeons, and they are precisely those for which a man in the country wishes to have some magisterial decision for his guidance. On the whole the work is sound, and any student who works faithfully through it will find that he has acquired a satisfactory knowledge of the present state of ophthalmological science, and will be competent to undertake the treatment of all ordinary cases that may fall under his care.

Food Adulteration and its Detection. By JESSE P. BATTERSHALL, Ph.D., F.C.S. Pp. 328. New York and London: E. & F. N. Spon. 1887.

THIS is essentially an American book. It aims at furnishing in a condensed form information of the present status of food adulteration in the United States. It contains a collation of American legislation on adulteration, and it is avowedly enriched from the reports of American State and Civic Boards of Health. As an outside view of the subject, however, it well repays careful study. To quote the author: "All attempts to awaken public interest in the subject of food adulteration are of any real service only as they may be conducive to the adoption of more advanced and improved measures for the suppression of the practice." To which might be added, that a study of the procedure adopted by foreign countries is always of service, as it tends to indicate directions in which our own measures of precaution are defective, or to show (which is rarely the case) that there is but small scope for improvement. So far as methods of detection are concerned, this book is not likely to be of very great service, the accounts being, as a rule, so condensed that reference must of necessity be made to larger manuals for their practical elucidation. On the other hand, it furnishes many valuable side-lights; as for example, of an injunction against the sale of certain teas being refused, because, although it had been proved that they were adulterated with gypsum, prussian blue, sand, &c., it was held also necessary to prove that these constituted a serious danger to public health. A valuable list is given of articles most exposed to falsification, together with the adulterants commonly employed.

The falsifications of tea by "facing" or "blooming" are well known, but their importance sinks almost into insignificance when compared with the adulterations of coffee. The relative consumption may be gathered from the statement that in 1885 the importation of tea approximated 82 millions of pounds, that of coffee being nearly 455 millions of pounds. The readiness of adulteration, and the relative laxity of administrative efforts to control it, are shown by 45·7 per cent. of 151 samples of ground coffee, purchased at random, being found to be adulterated.

With regard to the adulteration of beer, while asserting in emphatic italics that, *in past years*, cocculus indicus, picric acid, aloes, &c., have been discovered in bitter ale, the author quotes the following from Rüdlinger: "Cases of sickness frequently claimed to be caused by the beer, are due either to excess, or to the consumption of the new and incompletely-fermented beverage. It has been affirmed that brewers often economise in hops by the use of other and deleterious bitters, and that picric acid and strychnine have been employed for this purpose. Nonsense once written is frequently copied by hundreds, and in this way circulates among the masses." In another place the author speaks yet more strongly upon his own account about the non-employment at the present time of such poisonous substances as strychnine, hyoscyamine, picric acid, and picrotoxine. The very interesting account of the adulterations of wine might serve a double purpose if largely read. It should certainly aid the cause of temperance, and on the other hand, from the fulness of its detail, it might be serviceable to an ignorant sophisticator. Not only are the ingredients named, but the proportions in which they might be employed are also given.

The appendix of legislative measures relating to food adulteration is full of interest, the various Acts "to prevent deception in sales of dairy products" showing the importance recently attached to the various substitutes for butter. In Indiana an Act is enforced not only against the sale of impure butter, but also against "the keeping on any table at any hotel or boarding-house of impure butter." In New Hampshire an Act provides that no artificial butter shall be sold unless it is coloured pink. As a rule, however, branding with the name "oleomargarine" is regarded as a sufficient precautionary measure; more rarely is it considered necessary that the retailer shall deliver to the purchaser a printed label bearing the same word, and only in Arizona is it ordered that "dealers shall

keep posted up in their places of business this sign, 'Oleomargarine sold here.'" In short, as stated elsewhere in the book, very various opinions are held in America concerning the sanitary effects of olemargarine and other substitutes for butter, the only point of agreement being that they should be sold under their right name, and not substituted for genuine butter. The author does not express his own views upon this question; he quotes opposite opinions of the nutritive value of these articles, and leaves the whole matter undecided.

This book reflects credit upon both author and publisher. It is well printed upon good paper, and is illustrated with twelve photogravure plates.

OUR LIBRARY TABLE.

Public Health. By JOHN ROSS, M.B. King William's Town.—This small work professes only to contain a few chapters on the more important considerations affecting health in South Africa, and it has evidently been written with a view of arousing local public opinion on a subject that urgently calls for attention. The author deals in some detail with questions of soil, soil-pollution, the various systems by which nuisance from excrement disposal can be reduced, the removal of nuisances, whether of animal or vegetable origin, the prevention of infectious diseases, and the hygiene of infants. He has not failed to recall the experiences of this country in enforcing his views, or to quote from those who are admittedly authorities on the subjects treated by them. Action on the lines which are laid down cannot fail to promote public health, and thus to prevent unnecessary sickness and death.

La Pratique du Massage. Par W. MURRELL. Traduit par le Dr. O. JENNINGS. Paris: J. B. Baillière.—Dr. Murrell's guide to the therapeutical uses of massage is here translated by Dr. Oscar Jennings, who has added a few notes to the text. The present edition is prefaced by an introduction from the pen of Prof. Dujardin-Beaumetz, who takes the opportunity to point out that the medical man should make himself fully acquainted with the details of a method which he might often practise himself, rather than hand the treatment over (except in difficult cases) to the "masseur." He seems to infer that it is a drawback to a therapeutical measure to have it invariably placed in the hands of others than the medical attendant.

The Germ Theory of Disease. By FRANCIS W. CLARK, L.R.C.P., M.R.C.S. London: J. & A. Churchill. 1888.—This *brochure* consists in a review, mainly historical, of the progress made towards the determination of the organised causes of disease. It can lay no claim to originality, but it has the merit of bringing forward in clear and definite terms the leading facts that go to prove the theory of specific disease germs. Those who desire to refresh their memories with these facts might do worse than read this essay, which could serve well as an introduction to the larger treatises on the subject.

A Manual of Physiology, for the use of Junior Students of Medicine. By GERALD F. YEO, M.D. Dublin, Professor of Physiology in King's College. Second Edition, pp. 668, with 318 Woodcuts. London: J. & A. Churchill. 1887.—This student's manual may be thoroughly recommended to those for whom it is written. It is concise and clear, not burdened with references, written by one who knows his subject, and illustrated by excellent woodcuts.

Choice of a Site for Residential Purposes. By a Member of the Geologists' Association. Henry Sutton, Station-road, Redhill. 1887.—The author has, in the form of an inexpensive pamphlet, brought together a large amount of valuable information as to the importance of site for residential purposes. Questions relating to the remedial and preventive action of high-lying sites by reason of dryness, state of atmosphere, movement of air, exposure to light and sun, and other like considerations, are entered into. The views of the author are endorsed by a number of quotations from skilled observers; and the geological aspects of the subject are well set out in a form which is easy of apprehension, and which cannot fail to be useful.

Tratamiento de las Hemorragias por Retencion de la Placenta despues del Parto. Tesis leida. Por ANIBAL FERNANDEZ DAVILA. Lima, 1887.—This little work is a graduation thesis in the University of St. Mark, Lima, Peru. It does not profess to bring forward any new views or methods of the treatment of post-partum hæmorrhage, but the author seems fairly conversant with those in most repute in Europe. Regarding the making up of medicines containing ergot for the use of midwives, he believes it would be hopeless to forbid such to be sold to them in Peru, but suggests that these women ought to be instructed in the mode of action of this drug, and rules should be laid down for them which they could not infringe without liability to punishment.

ANTHROPOMETRY.

AT the Anthropological Institute, on April 24th, Francis Galton, Esq., F.R.S., President, in the chair, a paper by Dr. Venn on Recent Anthropometry at Cambridge was read, and was followed by a communication by the President on the Head-growth of Cambridge Students. During the Health Exhibition at South Kensington over 9000 persons were measured in Mr. Galton's laboratory, and a comparison of these measurements with those of the Cambridge men gives a result strongly in favour of the latter, as the following table clearly shows:—

	Height.	Weight.	Breathing capacity.	Pull.	Squeeze.
Cambridge	68·9	153·6	254	83	87·5
S. Kensington	67·9	143·0	219	74	85·0

These figures point to the high physical condition of the upper educated classes, and a comparison of these figures with those derived from the statistics collected by the Anthropometric Committee of the British Association shows that the average Cambridge student is distinctly above, and the average visitor to the exhibition about as much below, the mean of the general population in these particulars. The comparative brain capacity was calculated by multiplying together the maximum length, maximum breadth, and height above a plane passing through the meatus auditorius and immediately beneath the superciliary ridge. The men were divided into three classes: A, first-class honours men; B, all other honours men; C, "poll" men and failures. It was shown that the heads in class A were distinctly larger than those in class B, and that while both gradually increased in size from the age of nineteen to twenty-five, the superiority was steadily maintained; in the case of class C, which started with a smaller head than either A or B, the size increased with much greater rapidity than in either of the other classes up to the age of twenty-two and a half, when the curve was found to cross that of class B, and at the age of twenty-five the size of the head of the average "poll" man, although considerably less than that of the "first-class" man was slightly larger than that of the ordinary honours man. Mr. Galton also read a paper on the answers he had received from teachers, in reply to questions respecting mental fatigue.

A SANATORIUM, NORTH DEVON.—The foundation stone of a Convalescent Home was laid by Lord Fortescue (who gave the site), on the 23rd ult., on his estate at Morthoe. The Home will be erected at the cost—about £900—of Mr. W. F. Rock (the donor of Rock Park, Barnstaple) and his sister, Mrs. Payne; but the amount to be given is nearly £5000, a portion of which will be appropriated for an endowment. The institution will be under the control of the committee of the North Devon Infirmary at Barnstaple. Fourteen beds for males and females will be provided.

THE LANCET.

LONDON: SATURDAY, MAY 5, 1888.

THE movements for granting degrees to London medical students on terms which are equitable, and which will bear a fair comparison with those prevailing in the provinces and in Scotland, seem to be at present at a standstill. As we have shown again and again during the controversy, a much larger question than giving powers for granting degrees to the London Colleges of Physicians and Surgeons is involved. The condition of university education in London and the relations of the University of London to the Colleges and medical schools must be considered before a degree-granting power can be given to any new body or any existing corporation, and it is this large question of higher university education which the Royal Commission has been appointed to inquire into and report upon, and to which the obtaining of degrees is secondary. All the necessary documents and petitions have been before the Lord President of the Privy Council for some weeks past, but as yet the names of those appointed to serve on the Commission have not been made public. It is rumoured that Lord SELBORNE will be the chairman, but even this has not yet been definitely settled. It is apparently very difficult to find members of sufficient weight and importance to adjudicate on this question, who have not already in some way or other arrived at and expressed an opinion on the merits of the two university systems. Those who attach great importance to the professorial training and the contact of teacher and pupil will prefer a new university for London after the type of Oxford, Cambridge, Edinburgh, and Manchester; whilst those who consider that the function of a university is merely to grant degrees to all comers who attain a certain examination standard in arts, laws, science, or medicine—no matter how or where the knowledge is obtained—will be satisfied with the existing university. If the latter view be successfully maintained before the Royal Commission, we cannot see how the present injustice to London medical students can be redressed. It seems impossible, from its history and traditions, for the University of London to be so completely changed as to adapt itself to the requirements of the majority of London medical students, who are undoubtedly as well fitted for a degree as those now obtaining degrees elsewhere. Degrees obtained from the University of London are practically honours degrees, and must remain so, unless the examinations throughout, from matriculation to the M.D., be systematically lowered, and we can conceive no policy more unwise or more certain to be rejected by Convocation, even if passed by the Senate. Moreover, the University cannot be so reformed as to adequately discharge the local functions of a university whilst carrying out the work of an Imperial Examining Board. A glance at the Calendar shows that, except in vacation time, scarcely a week passes without some examination being held or arranged for, and the time and attention of the officials must be fully occupied with this necessary work, which is most efficiently performed by them, and which must suffer if they have to take on other duties. The scheme of reform, long promised, and now some two years in incubation, is not yet to be laid before Convocation, and this seems to indicate that its promoters are aware that it is insufficient for the requirements of the situation. Convocation will be asked on Tuesday next to take steps to bring its views, which have been shown to be very strongly in support of the existing system, under the notice of the Royal Commission, and this must again hamper the Senate in making any radical change in the constitution of the University. A new body connected most closely with our medical schools seems therefore the only adequate solution of the educational difficulty in London.

THAT differences of opinion should exist in the medical world is inevitable—nay, more, it is a sign of intellectual vigour, of freedom from prejudice, for scientific men *not* to follow every new theory in a flock. They do not accept it simply because it is new, or because there appear to be some arguments in its favour which for a while they do not see their way to refute. They may accept it provisionally as a working hypothesis, or they may stand aloof waiting for further confirmatory facts, and thus for the time the opinion of the medical camp is divided. Differences of interpretation are also matters of necessity. The same facts must always present themselves under different aspects to different observers. There cannot be any absolute uniformity of thought. By long concentration upon one subject the range of vision becomes narrowed, even though its perception for minutiæ within its area be rendered more acute. All judgment is based upon previous experience; hence a specialist is of necessity prone to trace the characteristics of his own subject in the fragmentary details ordinarily presented to him in the course of a short interview. The class of diseases he affects is ever present to him—his adversary lurks at his elbow like a phantom ever challenging combat. Recognising the impossibility of absolute agreement, the question remains whether any divergence should ever be openly, consciously expressed. In many cases doubtless a patient steals a march upon the profession by concealing all facts relating to previous medical treatment when in the presence of a consultant; but, on the other hand, there are sometimes occasions upon which those who meet in consultation arrive at different conclusions, and then arises the difficulty of avoiding a blunt announcement of the conviction of previous error of diagnosis or treatment. Judging the question by ordinary moral standards, there is no doubt about the course of action which should be followed, and from a professional ethical standpoint there can be no hesitation about the duty of the consultant. From time immemorial the theoretical course has been to express differences of opinion with all consideration in the presence of the colleague, and then to support him and to strengthen his position with the patient and his friends. The directions suggested by the College of Physicians for the guidance of its Fellows under trying circumstances are sufficiently explicit, and yet it is notorious that these directions are but too frequently set aside, and that much harm consequently results to the profession at large. It is not merely the relative position of consultant and general practitioner which becomes strained by a

disregard of professional loyalty; the evil is far more deep-seated, and extends to those slighting, disparaging remarks that are heard from colleagues occasionally, even of the same public institution. Petty personal differences are sometimes made manifest in casual conversation. The original source of this lack of harmony is perhaps lost sight of, or may be ignored by students, to whom the sole fact of interest remains that two colleagues, who by their position are equally pledged to instruct them, cannot agree upon what would seem to be first principles. In such cases, which are happily comparatively rare, students are almost treated like a jury: they are called upon to pronounce an opinion upon the merits of the disputed diagnosis or treatment, and yet, technically unskilled, their verdict is valueless; it is arrived at solely from a personal bias in favour of one or other of the disputants. It is extremely probable, however, that all such petty personal squabbles serve ultimately merely to amuse, even though they may lead to an almost calm indifference to the opinions or feelings of the teachers. Still it is undoubtedly objectionable, both in theory and practice, for personal differences to be openly paraded. That colleagues should differ is sufficiently lamentable, but by making their grievances public property, by slighting criticisms, or by more open measures, they do a great amount of harm. Whatever the merits of the case may be, they injure the institution to which they belong, by exhibiting it in the light of a battle-field rather than as a peaceful abode where scientific men are calmly and harmoniously working for the public welfare.

AT the recent German Medical Congress held at Wiesbaden, under the presidency of Professor LEUBE, one of the subjects discussed was the treatment of cases of chronic cardiac disease. The subject was introduced by Professor OERTEL of Munich, who restated the principles of diet and exercise, of which he is a well-known advocate. Hypertrophy, he pointed out, is an absolute or relative increase of the muscular substance, usually secondary; and its opposite, atrophy, produces thinning of the wall and dilatation. These are quantitative changes. The qualitative lesions, which likewise may be partial or general, are those due to inflammatory or degenerative processes. The more uncomplicated the case, the more amenable to treatment are these muscular affections. Historical retrospect shows how many changes have taken place in cardiac therapeutics. VALSALVA used to keep his cases of hypertrophy in bed, place them on low diet, and frequently bleed them. Later it was the practice to restrict diet, but to allow a limited amount of exercise. WUNDERLICH laid great stress upon the balance between the volume of blood and the force of the heart, and he sought to attain this by venesection. STOKES allowed regulated foot exercise, and gave lean meat; and to old subjects with degenerative lesions some alcohol. It was in 1875 that Professor OERTEL first applied dietetic and mechanical principles to the treatment of cardiac cases. He described three varieties of "fatty heart"—viz., those cases in which, with general corpulence, there is commencing weakness of the heart; those where "serous plethora" is combined with corpulence; and those in which a diminution of fat and albumen is accompanied by a notable loss of strength. All such cases require dietetic measures. The mechanical treatment consists in hill-climbing, which in health excites hypertrophy. Long-continued climbing produces permanent dilatation of arteries and increases the power of the cardiac contractions. Gymnastics have been advocated by SCHOTT as improving the cardiac muscle. It is also important to diminish the tendency to stasis; and this, again, is favoured by climbing, which increases the power of the heart and the number of respirations. To diminish the work of the heart as urged by WUNDERLICH, the chief measures consist in reducing the quantity of fluid ingested and increasing the excretion of fluid. The latter is also effected by mountaineering. In cases of arterial disease this mechanical treatment must be employed but cautiously; and indeed all cases should be carefully watched. Reports from mountain health resorts recount favourable results in cases of extensive fatty degeneration, with decided decrease of dropsy and corpulence; whilst in cases of valvular disease, compensatory hypertrophy, with relief to cyanosis, dyspnœa, &c., mostly follows this treatment. Dr. LICHTHEIM of Berne followed, with a warning against the indiscriminate adoption by patients of the OERTEL cure. He said that analysis had shown that in cardiac dropsy comparatively little change in the concentration of the blood is effected by removing fluid. Mountaineering was only favourable in such cases where the heart is able to deal with the more rapidly circulating blood; for the chief danger (indeed, the essential disease of the heart) lies in dilatation. All hypertrophy—whether from work, excessive ingestion, &c.—is preceded by dilatation; and dilatation is increased by the OERTEL cure. According to OERTEL, a mountain life leads to arterial dilatation, and the danger would be diminished by lowering of blood pressure. The supervention of dyspnœa in such cases should be taken as a danger signal. He also criticised the restriction of fluids in all cases; and concluded that the treatment by exercise should be prescribed in cases where compensation had long existed; and that drug treatment should not be commenced so long as compensation was present. When compensation failed, then resort might be had to digitalis, strophanthus, or caffeine. Professor ZIEMSSEN warned against the thoughtless use of OERTEL'S methods, the dangers of which were also alluded to by Dr. SCHOTT, who advocates salt baths and gymnastics. Dr. EDELSEN commended the prescription of iron and camphor in cardiac cases.

A RATHER nice point in the interpretation of the Vivisection Act of 1876 was brought under the notice of the Lord President of the Privy Council on the 24th ult. by a deputation from the Royal Agricultural Society of England and the Royal Veterinary College. It appears that in order to avail himself of the latest resources of science Lord EGERTON of Tatton had some of his herds inoculated for quarter-ill. The inoculations were performed by Professor PEMBERTHY, who some time afterwards received a letter from the Home Office to the effect that he had rendered himself liable to prosecution for conducting "experiments" without a licence. Lord EGERTON stated that the inoculations were performed in the *bonâ-fide* belief that they would prevent the disease, and he quoted facts which went to show that the operations had been largely efficacious. He naturally asked what

constituted an "experiment," and a reply sent from the Home Office to this question was to the effect that when inoculations were practised in the belief of their efficacy they came under the head of simple veterinary operations, but when performed to test a theory they would constitute experiments under the Act. Lord EGERTON contended that inoculations were just as *bonâ fide* as many other veterinary operations—such as firing and rowelling, which were of doubtful efficacy; and said that the Royal Agricultural Society wished that this matter should be cleared up, and that operations of this kind, performed at the risk of the owner, should not be classed as experiments within the meaning of the penal clauses of the Act. The Home Secretary and Professor BROWN, who were with the Lord President, also expressed their views. Professor BROWN said that from a scientific point of view he quite sympathised with the object of the deputation. Whatever was done for the purpose of testing anything was really an "experiment," and he instanced his own inquiry into swine fever, which had resulted in obtaining an inoculating fluid that would most probably prevent the disease, but which could not be employed by veterinary surgeons without a licence. He contended that in the inoculations in question the operator proceeded, not with a *bonâ-fide* belief, but with a *bonâ-fide* intention to benefit the animals upon which he operated. He thought that veterinary surgeons should be placed in the same category with respect to these new methods as medical men are with regard to their use of new remedies; and that the Act should not apply to such operations performed with the intention of treatment. The Home Secretary said he had endeavoured to distinguish between "experiment" and "treatment"; and he thought that where there was a *bonâ-fide* desire to benefit the animal without any belief or knowledge one way or another, such operations were not experiments. He confessed, however, to a difficulty in dealing with the subject; and the Lord President regretted that there had been no attempt to get a legal decision on the point. He personally expressed the opinion that where operations were done with a reasonable chance of success, based on previous knowledge, they should not be regarded as experiments. He promised that his Department would give the matter careful consideration, and see if any way out of the difficulty could be found.

There is no doubt that this question will have to be met by legislation. It cannot be supposed that the members of the veterinary profession are to have their hands tied in the performance of what may properly be regarded as one of their most important duties. The protection afforded by inoculation in some of these highly infective and fatal diseases has in some instances received so much confirmation that, as will be seen, not even the Home Office could construe such operations as violations of the Cruelty to Animals Act. Nevertheless, the position of veterinary surgeons in the matter is by no means clear, and the result of the deputation cannot, we think, encourage them to utilise the advances of science, since they may thereby be rendering themselves liable to criminal prosecution. It is therefore time that the question should be determined, and we may confidently look for some amendment in the law, of which the interpretation was somewhat strained by the Home Office in the letter to Professor PEMBERTHY.

THE Registrar-General has just issued his Quarterly Return for the first three months of the year, which shows that the public health during that period was exceptionally favourable, if the severely wintry character of the weather in the quarter be borne in mind. The mean temperature of the first quarter of this year was nearly 2° below the average for the corresponding period in 117 years. The temperature in January showed an excess, while the deficiency was 3·8° in February and 3·1° in March. Indeed, the cold period between the 11th of February and the 6th of March was for length and severity without parallel since 1855; and, in addition to the low temperature, biting north-east winds prevailed to an unusual extent, and the amount of recorded sunshine was less than half the average amount. Notwithstanding these unfavourable conditions, the general death-rate last quarter did not exceed 21·0 per 1000, and was 1·0 below the mean rate in the corresponding periods of the ten years 1878-87. If we except the first quarters of 1884 and 1887, when the death-rate was 19·5 and 20·6 respectively, the rate last quarter was below that recorded in the first quarter of any year since the commencement of civil registration in 1837. Compared with the mean rates in the first quarters of the last seven years, the death-rate last quarter in the aggregate urban population was 0·9 below, while the rate in the remaining or principally rural population was 0·4 above, the average; thus the effect of the cold wintry weather of last quarter was more definitely shown in rural than in urban districts. Again, the effect of the cold weather was most distinctly shown on the death-rate of young and old; it appears that the mortality of infants aged under one year, and of persons aged upwards of sixty years, exceeded the mean rates in the ten preceding corresponding quarters by 1·4 and 3·5 per cent. respectively, while that of persons aged between one and sixty years was 8·3 per cent. below the average. Judged by the mortality from the principal zymotic diseases, the health condition of the people was satisfactory; the deaths from those diseases gave an annual death-rate of 1·84 per 1000, while the mean death-rate from these diseases in the ten preceding first quarters was 2·20. The mortality from measles, scarlet fever, "fever" (principally enteric), and diarrhœa was very considerably below the average, while that from whooping-cough and from small-pox showed a slight excess, and the excess of mortality from diphtheria was considerable. Although the mortality from scarlet fever was little more than half the ten years' average, it showed a marked excess in Lancashire, the West Riding, and in South Wales. The largest excess of diphtheria mortality was recorded in Essex, the extra-metropolitan part of Middlesex, Cambridgeshire, and Huntingdonshire. Fever mortality was marked in the neighbouring counties of Leicester, Lincoln, Derby, and Nottingham, notwithstanding the low rate in the whole country; and the death-rate from measles showed a large excess in the counties of Nottingham, Derby, Northampton, Gloucester, and Monmouth, although the general rate was less than three-fourths of the average rate. The 583 deaths from small-pox registered during the quarter exceeded the number returned in any quarter since the spring of 1885; the

excess was entirely due to the epidemic in Sheffield, where 318 of the 583 deaths occurred. More than 100 of the other deaths from small-pox occurred in other parts of the West Riding or in Lancashire towns in intimate communication with Sheffield, so that it is impossible to say what proportion of the deaths from this disease last quarter were more or less directly due to the epidemic in Sheffield, which began in August, 1887, and which would probably not have assumed a serious character if that town had been provided with efficient hospital accommodation for the isolation of the early cases. Not the least satisfactory feature of the Registrar-General's Quarterly Return is the abundant evidence it affords of generally improving sanitary condition, and of the power of preventive medicine to control zymotic mortality, and still further to reduce the national death-rate, or, in other words, to prolong healthy life in England.

Annotations.

"Ne quid nimis."

UNIVERSITY OF LONDON.

THE annual meeting of Convocation of the University of London will take place on Tuesday next, the following day being Presentation Day. The Report of the Annual Committee embodies a resolution to enable that body and the Special Committee appointed in December, 1885, to take steps with reference to the representation of the views of Convocation to the Royal Commission about to be appointed to inquire into the condition of the Higher Education in London. A long report of a Special Committee appointed to consider the Regulations for the Examinations for Degrees in Laws is appended to the Annual Committee's Report. There are several motions on the agenda, many of which will probably share the usual fate of being deferred to a future meeting. Whether the proposal made by one graduate to alter the hour of meeting from 5 to 7 P.M. would have any better effect in "keeping a House" on these occasions may be questioned, for the interest taken in the proceedings of Convocation is, it must be confessed, comparatively small.

THE MEDICINE STAMP TAX.

A FEW months back we were sanguine enough to hope that, when Mr. Goschen came to readjust taxation in the course of his Budget arrangements, he would deal among other things with the medicine stamp tax, and, having regard to its great and manifest iniquity, would abolish it altogether. But unfortunately that is not to be. The novelties which Mr. Goschen has produced have been of exactly the opposite description. He is all for imposing little taxes. Horses and wheels are made contributory in order that he may be able to remit a penny of the income tax, and, though it is hard to quarrel with the remission, we are bound to confess that we feel great disappointment with the whole result of the Chancellor's lucubrations. Some evil genius would seem to have beset especially those particular interests which constitute our especial charge. Horses, wheels, and medicine: would it be possible to devise a scheme of taxation more admirably adapted to aggravate the "*ills* that flesh is heir to"? It almost makes us doubt whether we ought not to congratulate ourselves that it has not yet occurred to our financiers to lay a tax upon prescriptions. But, seriously, we commend this subject to our readers as one worthy of consideration, and exertion too. The grounds of objection to the medicine stamp tax have been so often stated in these pages that we hesitate to repeat the story. In a word, the tax is so mischievous as an advertisement for pernicious compounds, and so oppressive as a burden upon useful ones, that it ought at any cost to be at once repealed. When it is added that the cost of repeal would be no more than £150,000 a year, the case against it is complete, and wants no more the weight of argument, but only the propelling force of organised effort.

CORPORAL PUNISHMENT FOR BOYS.

THE value of kindness as an aid in training cannot be denied, and the discipline which excludes it and relies only on compulsion is not likely to fulfil its purpose. It may, indeed, exact of the learner a grudging submission to duty, but it cannot kindle in him the zeal of willing service. It may make him hardy, but if so it will also make him surly. The work he does may be fairly done, but probably not, for him, very well, and his better nature is crippled in the process. We are no advocates of any such system as this. On the other hand, it would be highly unreasonable to exclude corporal punishment altogether from the usages of school life, at all events in the case of boys. Suasion alone will not avail for every instance in which a pupil's will is idle or obstinate, and of this fact boys are well aware. They look for something more as constituting an authority worthy of obedience. They feel instinctively that all through nature's law a certain hardness mixes with the merciful quality of justice, and that government without this may be enjoyed, but need not be respected. In these circumstances it is clearly unwise, and in the end unkind, to spare the rod always. Now and then it must be used, and, if judiciously applied, is open, so far as we can see, to no objection. It is commonly advisable, doubtless, to exempt children of really delicate constitution. So likewise must all striking at random be condemned, and particularly the once common custom of boxing the head and ears. That well-covered region of the dorsal surface which so often bears the needful assaults of discipline would appear to be the part of the body designed by Nature to serve for purposes of correction. Teachers in inflicting chastisement cannot do better than apply the birch in conformity with her evident suggestion, and of course only when the mere assertion of authority is ineffectual.

FIFTY YEARS OF SANITARY WORK.

DR. H. J. PAINE, the well-known medical officer of health for Cardiff, takes leave of his sanitary authority in his annual report for 1887, and all will wish him every enjoyment in the comparative leisure which he seeks and has so well earned. The report traces the sanitary history of the borough from 1839, when typhus was found by him, during a temporary employment, nearly half a century ago, to be rarely absent from the place. In 1847-49 the disease was epidemic, the death-rates per 1000 from the then "fever" standing at 4·7 and 3·0 respectively. Energetic measures were adopted by means of bye-laws and sanitary inspection to control the evils which tended to the diffusion of the poison, common lodging-houses and conditions of overcrowding being especially dealt with; the result being that the mean "fever" rate for the three years 1855-57 had already fallen to 0·5. Since that date typhus has been absent as an epidemic; but its recurrence on a comparatively small scale in 1885 shows how soon this contagium seeks out its natural breeding places. The disease was found in an overcrowded court; some of the houses had only a basement and a bedroom with no through ventilation, and in one of the rooms no less than eight cases were discovered. The infection spread, and before it could be checked fifty-one attacks and nine deaths had occurred. But "fever" now, in Cardiff, no longer means typhus, the enteric type of the

disease being almost the only one met with. Of cholera much the same may be said as of typhus. Three times the disease assumed an epidemic type, but when danger was again imminent in 1885, owing to communications with Italy, the sanitary progress which had in the meantime been made, and the special arrangements as to isolation and otherwise which had been matured, sufficed to deal with the risks incurred. In enumerating the great sanitary works carried out, prominence is naturally given to works of drainage and of water supply—works in which a sum of over £996,000 has already been expended. But a substantial portion of this expense has turned out to be itself a source of income; and not only so, but whereas during the twenty years ending 1856 the mean annual death-rate of Cardiff was 31·5, there followed after that date a steadily maintained diminution in mortality, the rates for the three decenniads between 1856 and 1886 being 25·7, 22·6, and 20·7 respectively, the actual saving during the thirty years amounting to 15,480 lives. This saving, on the estimate of the late Dr. Farr, who held that the money value of a life saved to the productive industry of the country amounted to £300 if a male and £150 if a female, would indicate a total value equal to £3,483,000. Fortunately for the credit of British sanitary administration, the case of Cardiff does not stand alone, but the special characteristics and difficulties attaching to a place which is both a great trade centre and a port give a more than common interest to the important results which have been so largely brought about by the labours of a life devoted to the public weal.

MEDICAL DEMONSTRATIONS IN THE DRAWING-ROOM.

IT is a strange fact, and characteristic surely of a false purpose in the age in which we live, that an attempt is actually being made to define the position of medicine in the round of social entertainments. Hitherto we have been accustomed to look upon disease as a painful reality, and the practice of physic as a serious endeavour to meet and overcome its inevitable evils. In so thinking, it appears, we have been mistaken, and we may now expect to find that neither is incompatible with the ordinary diversions of the drawing-room. A few weeks ago we noticed the keen relish for surgical operations and demonstrations of a like character which is said to prevail among the curious in Parisian society. A feature of the time more characteristic of the absence of sound good feeling it would be difficult to find. Hardly less objectionable, however, though ostensibly introduced by a worthier motive, is the effort which is being made, according to some of our contemporaries, by the National Health Society to inaugurate a system of drawing-room education in medicine and surgery, accompanied by practical illustrations, in which the audience will participate. Whether we regard this movement as a *bonâ-fide* attempt at popular instruction, or as a new amusement for intellectual circles, we find nothing to say in its favour. However useful it may be to inculcate the principles of first aid to the injured and the like, anything like this systematic attempt to show how one may play the doctor for himself—may do with life and limb as the conjuror does with plates or cards—is at once most dangerous and most absurd. It ignores, among many other considerations, the patent fact which is at the foundation of all medical education and practice—viz., that before diagnosis and treatment there must come a wide and intimate knowledge of the human organism and its variations in health and disease, and this is a matter with which drawing-room discourses, however fully and practically demonstrated, are quite incompetent to deal. There is not, indeed, any section of medicine or surgery worthy of the name which can be effectively handled by this very imperfect process of teaching. On the other hand, the injury which is likely to be sustained by the national health in consequence of the clumsy application of crude principles thus imperfectly taught and understood is considerable. We have become only too familiar with fatal negligence in illness as an error of the sect of the Peculiar People. What the Health Society proposes is practically to develop this dangerous peculiarity among the educated classes by teaching an impossible doctrine of self-medication, over which it spreads the ægis of a falsely so-called sanitation. This is not, of course, the purpose of the new movement, but it bids fair to become its ultimate result. As regards the æsthetic aspect of the question we need say but little. We are sure, however, that there is a widely prevalent opinion on this point which does not favour the project of the Health Society. We are by no means alone in thinking that the free-and-easy representation of disease and its treatment in the manner contemplated can only serve to impress most persons with a sense of indignity done to the subjects discussed as well as to the decencies of social life.

CASE OF PRIMARY ACTINOMYCOSIS OF THE BRAIN.

AN example of a primary actinomycotic tumour in the human brain is referred to in abstract in a recent issue of the *Centr. f. Bakteriologie*. The details of the case were published by Professor Böllinger last year in the *München Med. Wochenschr.* The patient was a woman twenty-six years of age, who had long presented symptoms of brain tumour; and after death the diagnosis was confirmed by the discovery of an oval tumour the size of a large hazel-nut, of smooth surface and pale greyish-yellow colour, situated between the anterior pillars of the fornix and upon the anterior commissure of the third ventricle. Microscopically the gelatinous contents of the growth were found to be composed of lymphoid and granulation cells, together with numerous colonies of actinomyces in various stages of development. Ponfick has recorded two instances of secondary actinomycosis of the brain, but the present case is the first recorded instance of a primary tumour of this kind in that organ. Attention is drawn to the circumscribed character of the growth induced by the fungus. How the patient was infected was unexplained; but it was surmised that the parasite may have been introduced through food (raw vegetables or milk), and that it must have gained entrance into the circulation. Out of ninety recorded cases of actinomycosis collected by Moosbrugger, the path of invasion was undetermined in 10 per cent.

QUACK DOCTORS PUNISHED!

CONSIDERING the rampancy of quackery, it is remarkable how seldom we hear of it being punished. Let us emphasise a recent instance of well-merited nemesis. Five men—Henry Chadwick, John Wilson, John Kay, Raphael Shires, and Harry Thomas—have been tried at the Manchester Assizes for conspiracy to defraud. They practised as quack doctors, though they had no qualifications. One had been a betting clerk, another a bill poster, &c. They had succeeded in extracting large sums from their victims. One client had been fleeced to the extent of £190. Two of the men, Wilson and Thomas, were servants to the rest, and were discharged. The others pleaded guilty, and were sentenced—one to eighteen months' hard labour, and the other two to a third of that term each. We agree with a morning contemporary that this punishment is too light for such impudent and injurious fraud. But two questions present themselves: Why is the punishment of quackery so limited? The market-place of every country town is systematically visited by men who defraud the poor. Some of these quacks are regular residents,

and ply their business with assiduity, and not always with impunity to the public. But they go scot free; and their dupes pocket the injury they receive, no doubt feeling ashamed that they have made fools of themselves. The other point to be noticed is the contrast between the niggardliness with which people stint the payment of medical men, and their lavishness when pretenders and quacks have to be paid. The man who cannot scrape a few shillings together to pay a doctor's bill, and who will pauperise himself to escape one by going to the nearest dispensary or hospital, will soon find a guinea or two to buy a quack medicine; or his friends, who will make no contribution to the payment of the honest doctor, will combine to pay a huge fee to any ignorant pretender who advertises his ability to do the impossible.

HYDROPHOBIA IN ITALY AND AUSTRIA.

THE Milanese Commission for the Prevention of Hydrophobia has deputed two of its number—Drs. Secchi and Segré of the Spedale Maggiore—to proceed to Paris to make further researches into the Pasteur method of inoculation, and to frame a report on the results of the last three years' experience of its practice. In the Austrian Legislature, a motion to adopt the method, as having already justified itself, and to aid its further application throughout the Austrian dominions by a State grant, was not carried. Dr. von Wiedersperg, who introduced the motion, basing his demand for State assistance on the results of Dr. Ullmann's practice in Vienna, was met by the Budget Committee with the objection that interesting as those results were—three hydrophobic patients only having died out of one hundred and twenty-two inoculated on the Pasteur method—there were yet sources of fallacy in the experiment which had yet to be considered. Although Dr. Ullmann's figures were rather more satisfactory than those hitherto yielded in cases of persons bitten by mad dogs and not inoculated, the committee was of opinion that it had not yet been made out that in all Dr. Ullmann's patients the existence of the hydrophobic poison had been scientifically established—many of the patients in question having come from abroad, and having later returned to their homes. With every recognition of the humanitarian spirit of Dr. von Wiedersperg's motion, the committee required further proof of the efficacy of the Pasteur method before advising the Government to grant sums in aid of its extension throughout Austria, or even for the maintenance of a special institution for the Pasteur treatment of hydrophobia.

THE ABOLITION OF GROCERS' LICENCES.

AMONG the various reforms included in the new Local Government Bill there is one to which we cannot in the public interest refuse our hearty support. This is the contemplated abolition of the grocer's licence. By what plea of necessity this arrangement can possibly be excused we are unable to discover. Of restaurants in some form there is in every town, almost in every village worthy of the name, a sufficient number, and of public-houses by far too many for the ordinary requirements of wayfarers. No valid reason can therefore be urged on the ground of general utility to show why the grocer should add to his proper function of providing for household consumption another office, which is virtually that of a disguised publican. In some country districts, it may be, the provision store must serve to some extent the purposes of a house of call; but there is no absolute necessity even here for the so-called "off licence." What we particularly object to about this latter is its undoubted tendency to encourage secret drinking. The evil influence of successive littles imbibed in a quiet manner is well known to be quite as hurtful to the health of the toper as the unbridled and more occasional excesses of the open drunkard. Yet the former will often avoid a professed drinking bar. It is for his interest as a respected, if not highly respectable, person to do so, and the grocer's licence is for such as he a veritable special providence of municipal arrangement. We understand, of course, that the law cannot restrain an ostensibly sober person from procuring drink if he chooses, but it is nevertheless quite within the province of the Legislature to restrict his opportunities for ruinous indulgence, especially when its action can in no way interfere with public convenience. On this principle the change proposed by the new Bill is entirely justified. We anticipate beneficial results from its operation, not so much perhaps in the case of the chronic inebriate as in that of many young men and women, to whom the off licence affords a tempting facility of descent, which we fear is often hopelessly irresistible. There appears to be no reason why the holders of these licences should not receive compensation in some form if, as we anticipate, their present privilege is withdrawn. Into this part of the question, however, it is not necessary for us to enter, and we may safely entrust its settlement to the joint consideration of the Government and the representatives of the licence holders.

THE McINTYRE GIFT TO THE STUDENTS OF GLASGOW.

DR. JOHN MCINTYRE of Odiham, who some years ago conferred the gift of £1000 on the poor of his native place in remembrance of his father and mother, has now done an act of distinguished generosity to the Medical School of Glasgow, of which he is an *alumnus*. At a cost of £5000 the students of Glasgow have now been provided by Dr. McIntyre with a splendid Union Club building, erected in the University grounds, and containing a library, a hall for debates, a dining room, convenient committee rooms, and every arrangement for a perfect house of the kind intended. By the request of the liberal-minded donor, the advantages of the Union Club will not be strictly confined to students of the University. Under certain regulations extra academical students will be admitted to membership—a wise and just rule, and one that will do much to foster good feeling amongst the rival classes of the different schools of medicine of the city, and to tone down asperities which in past days have been sometimes rather keenly experienced. We are sure that every sincere friend of medical Glasgow will expect soon to see the Union Club completed; and, hoping for its long and successful career, will wish its generous founder many long days of life and health to witness the growth and development of his happy as well as munificent project.

LIQUOR TRAFFIC AND NATIVE RACES.

A GREAT deal of time was recently expended in the House of Commons in a debate upon the above subject. Practically there was complete unanimity. Every speaker expressed the horror he felt at the introduction of the habits of drinking among uneducated natives. All deprecated the unrestricted sale of intoxicants. The helplessness of legislative interference was evidenced by numerous examples of evasion of the law by colonists or traders of other than British nationality. But still the fact remains that in far too many colonies, in spite of legal restrictions, drink is supplied to the natives at extraordinarily low prices, which appear to leave no margin for profits. The form of spirit known as "Cape Smoke" is sold at 6*d.* a bottle; its taste is so unpleasant that it is not consumed by Europeans; it possesses, however, strong stimulant properties, the natives who drink it getting greatly excited and quarrelsome. Mr. A. McArthur, who introduced the subject in the House, spoke of the liquor traffic as responsible for

wholesale murder in the islands of the Western Pacific. In Africa, he said, the consumption of strong drink was rapidly increasing, and leading inevitably to the demoralisation and destruction of the native races. He instanced one locality where in two months 106 natives were destroyed by drinking brandy. One writer quaintly said the liquor traffic did not at present affect the natives of a certain island, as he had been there some years back, when the last native died. This extinction of the natives may in part be due to their inability to withstand the inroads of diseases, which on reaching a new unprepared soil appear to gain in virulence. On the other hand, there is no denying that it is largely the result of the great difficulty experienced by the natives in acquiring the habit of self-control in the presence of the temptations of stimulants.

MEDICAL ADVICE THROUGH A PHARMACEUTICAL JOURNAL.

MEDICAL CONSULTATIONS through the columns of newspapers are by no means confined to this country. The *Concours Médical* complains that French pharmacists are adopting this method of giving medical advice, and quotes from a provincial pharmaceutical journal two answers to priests who have apparently been endeavouring—possibly with the best and kindest intentions—to obtain some reliable advice for sick parishioners gratis. In one case, that of a female, M. l'Abbé A—— is advised to note exactly the hours at which the fever returns, and if the patient will not take the quinine powders to have recourse to hypodermic injections. In the other case, M. le Curé de B—— is advised to give "his patient" fifty centigrammes of bromide of ammonium on going to bed. And this it must be remembered is in a country where, nominally at least, the prescriber and dispenser must be different persons, doctors not being allowed, except where no pharmacy is near, to dispense, and pharmacists being forbidden to prescribe. What is the use, cries the medical journal above named, of the boasted Argus eyes of Justice? To prosecute and fine a hospital house surgeon when he temporarily acts with the full authorisation of his chiefs; to fine doctors who refuse to betray professional confidences; to worry men by constant demands for their diplomas; to make use of and abuse the power of law over medical men by compelling them to attend inquests, to make examinations, and to give information of various kinds, throwing them fees which one would sometimes not think of offering as *pour boires*. The fact is, according to the *Concours Médical*, that radical reforms, both medical and pharmaceutical, are urgently needed. There should either be complete freedom for all or intelligent and properly enforced regulation.

GONORRHŒA IN RUSSIAN MILITARY HOSPITALS.

DR. BULFOBICH, referring to a report by Professor Tarnovski on venereal diseases in the military hospitals of European Russia, which was published after a special tour of inspection undertaken some eight years ago, complains that the recommendations made therein regarding the importance of a better supply of instruments for examining and treating urethral diseases have not been followed by any improvement in the armamentaria allowed, and that consequently the treatment of gonorrhœa, and gleet in particular, cannot be carried on in many cases with anything like scientific precision, the old rule-of-thumb methods leaving much to be desired. In this way the country loses the services of the men who have contracted gonorrhœa for a much longer time than is necessary, their stay in hospital being frequently very protracted. Dr. Bulfobich illustrates this by giving some statistics from the reports of the Caucasian army, to which he himself is attached. In this part of the Russian army, the official medical report for 1885 shows that there were 32·68 venereal cases per 1000 of the strength 18·82 of these being returned as gonorrhœa. In one of the military hospitals in the Caucasus—that of Timir-Khan-Shurinski—the average stay of the cases of gonorrhœa during the first half of 1887 was found to be 49·1 days, the period of detention varying from 9 to 199 days. According to Professor Taranovski, an average detention of 32 days for gonorrhœa is exceptionally long if the cases are treated scientifically; but for really good results to be obtained, not only must the surgeon have at hand complete sets of sounds, both metallic and soft, but a urethroscope, and a fluid caustic apparatus for the deep parts of the urethra, which are as necessary to a proper system of treatment for urethral diseases as the ophthalmoscope is for the management of eye cases.

SANITARY ADMINISTRATION IN CALCUTTA.

THE Calcutta correspondent of *The Times* has telegraphed that Dr. Simpson's statements as to the sanitary condition of parts of that city have offended the acute susceptibilities of the native commissioners, and that Dr. Simpson has been solemnly called upon by a formal resolution to explain away or withdraw his description of them as discourteous and disrespectful. Dr. Simpson's excellent work in Calcutta has been closely watched in England, as well as the difficulties with which he has had to contend; and the enemies of local government in India will not be slow to see, in the treatment he is receiving at the hands of the native commissioners, a strong reason for depriving them of a power which they appear unable to exercise with wisdom and justice. Certainly the sympathies of all right-minded persons in England will be with Dr. Simpson in his efforts to remove the causes of cholera from his district. This is, indeed, matter of more than local concern, and as such we do not doubt it will be treated. The maintenance of conditions which foster cholera in India cannot be disregarded by England, or even by Europe.

THE SOURCES OF SKELETON SUPPLY.

IT is, perhaps, a fortunate thing that those who have to study the composition of the human skeleton need not concern themselves with the history of the preparations which they handle. We all know that the bones, whose beautiful whiteness is the admiration of many a student, have previously passed through an elaborate cleansing process, and some of us have doubtless wished, in the interests of study, that, in the transformation, anatomical marking was less often sacrificed to beauty of appearance. The process itself, which is largely carried on in France and Germany, consists of two principal parts—that of boiling and that of bleaching. The "material" thus prepared is of very various origin. It is said to be derived chiefly from hospitals, prisons, and dissecting rooms, while we also learn from a contemporary that the late Russo-Turkish war contributed largely to the store rooms of the skeleton-making establishments. This is a statement which may shock some readers, but we should remember that it does not really prove such a striking disregard for the right of sepulture as it may at first sight appear to imply. Hospitals and infirmaries, by affording for dissection the bodies of patients who die within their walls, unclaimed by relatives, render most efficient assistance to the teaching of practical anatomy, and we know of no reason to regret this very needful arrangement. We confess, however, to a certain feeling of dissatisfaction at learning that the brave and not unfriended dead who have yielded up their lives on the battle-field are liable to disturbance in their last sleep, and to dismemberment by bone-seekers. No doubt they

are unconscious of the treatment they receive, and their relatives in another land, it may be, know nothing of it, and yet it seems as if the claims of honesty and due respect were disregarded in this case. It would be well, perhaps, if some of our continental neighbours were to acquire a measure of that feeling which they call the English "spleen," and they might then agree with us that a life and death of soldierly devotion are at least deserving of a grave.

"HOMŒOPATHIC LEAGUE TRACTS."

HOMŒOPATHY has throughout had marks of quackery. One of the most unmistakable is its appeal from the profession to the unlearned. Discarded and discouraged in every medical society, and in all the universities of Europe, it has sunk so low as to distribute tracts calculated to impress the vulgar, in which the most ridiculous arguments are used, and the most unworthy motives are ascribed to the medical profession. We have not noticed these "Homœopathic League Tracts" in detail, and we have no intention of doing so. One is now before us, and we may take it as a sample. It is entitled "Allopathic Misconceptions of Homœopathy," and descants on the ignorance of medical men in regard to the "great" subject of homœopathy. The most honoured men in the profession, and those whose names stand out conspicuously as having advanced medical science, are shown to be most hopelessly ignorant of homœopathic science, or, worse still, of that moral principle which would lead them to do it justice and to fall down and worship Hahnemann! The rank and file of the profession are represented as abettors of the immoral use of narcotics, and of any theory or mode of treatment that promises to give the doctor more to do! They adopt with uncritical haste any innovations which do not diminish their profits! The germ theory and the doctrine of the prime importance of subduing pain are adduced as illustrations of this immoral credulity of medical men. This is a pretty cool libel of the profession of Jenner and Simpson, of Parkes and Simon and Lister. Sir Joseph, who has the slight distinction of having wellnigh abolished erysipelas and gangrene—in hospitals at least,—and a few other such plagues, "is" (so the ignorant readers for whom the "Homœopathic League Tracts" are prepared are told) "now seldom spoken of." Times must be very bad with homœopathy when its advocates have to resort to such weapons as this, and to appeal to an audience that can receive such statements. The author of this tract, indeed, admits as much. He talks of the flowing tide being with the homœopaths, but he says "*it seems to flow but slowly in Britain and Europe.*" So we think. And our homœopathic friends will find that the great public of the end of the nineteenth century is not going to accept a theory of medicine which involves the detraction of those benefactors who have done so much to relieve the suffering of their fellows. It would be as reasonable to accept a theory of chemistry that left out the work of Lavoisier and Davy, or a theory of biology that discarded Darwin and Huxley. The instinct of the public—not its knowledge—keeps it from such a fatal blunder, in spite of "Tracts" and "Leagues." This seems the last card of homœopathy, and it is a veritable confession of failure. No wonder that "the tide flows slowly" in favour of homœopathy when it has to live by traducing medicine and the leaders of medicine. But there is another reason—the exceeding attenuation of its achievements. Here is its disparity in the conflict with true medical science. After nearly a hundred years of boasting it cannot be credited with one palpable effect. It is easy to decry the germ theory and the remedies which relieve pain. But what would homœopathy give for such fruitful and palpable additions to scientific discovery, and to the abatement of human misery and disease as are represented in chloroform and its congeners, or in the antiseptic and germicidal theories of disease, or in the great results of the allopathic treatment of hyperpyrexia. The achievements of homœopathy are, like its doses, impalpable.

HOSPITAL PROVISION AROUND BRADFORD.

WE have already drawn attention to the somewhat complicated position of affairs which has been brought about in the neighbourhood of Bradford by the transference of the Bradford Fever Hospital to the Corporation of that borough, subject to a payment of £4000 to be made to the guardians of the surrounding North Bierley Union for the provision of similar accommodation to take the place of that which will no longer be available. Unfortunately, the guardians are the wrong body to receive this compensation; whereas no less than seventeen urban sanitary districts have a claim upon it. Under these circumstances appeal was made to the Local Government Board to advise as to the allotting of the money, and as to the best arrangements for meeting the wants of all these districts as regards isolation. The result has been an investigation of the circumstances affecting the district by Dr. Barry, and at a recent public meeting Mr. Kennedy, barrister-at-law, was associated with him in conference with the several sanitary authorities concerned. The final proposal made is that the seventeen sanitary districts comprised within the North Bierley Union shall be united into four districts for hospital purposes, each group to be constituted under a joint hospital board, and each to receive towards the commencement of building operations a certain proportion, based on population, of the £4000 named. With the exception of four districts, the representatives of some of which were unable to make up their minds, the several bodies meeting in conference assented to the scheme, and it is to be hoped that a plan so obviously reasonable and likely to suit the requirements of the sanitary districts involved will not be allowed to fail because of a few dissentients. It was also suggested that, at the expiration of two years, any district which had remained out of the amalgamation and had neglected to provide hospital accommodation should have its proportion of the funds handed over to the hospital board exercising jurisdiction over the area to which it geographically belonged—a suggestion which appeared to meet with very general acquiescence.

EXPERIMENTAL TYPHOID FEVER.

AFTER reviewing the literature of the subject of experimental typhoid fever, and after detailing the results of some fresh experiments, Dr. Perret, in the *Province Médicale*, No. 16, comes to the conclusion that Eberth's bacillus freshly taken from the human body, whether living or dead, does exhibit a poisonous effect when injected into certain animals. The resulting experimental disease, however, does not bear a faithful resemblance to true typhoid fever, but is really a septicæmia, perhaps capable of a certain measure of attenuation, as seemed to be indicated by the recent researches of Perret and others.

THE AUSTRALIAN DENTISTS ACT OF 1887.

THE colony of Victoria has passed an Act to regulate the practice of Dental Surgery. The measure follows very much the lines of the Dentists Act in this kingdom. It provides, says the *Journal of the British Dental Association*, for the formation of a Dental Board consisting of five dentists and three doctors holding office for three years, and a Dental Register is to be compiled. It will not interfere with vested interests—that is, all persons practising dentistry at the time of the passing of the Act, whether qualified or not, will be entitled to register.

HEALTH OF THE GERMAN EMPEROR.

A TELEGRAM received on Thursday evening at our office states that the Emperor is gradually gaining strength; the discharge from the abscess is still abundant; the laryngeal disease, however, remains quiescent. There has been no material change in the state of the German Emperor during the past week. There have been slight daily variations but no decided improvement. There is still a tendency to fever every night, and the inflammation around the trachea has not wholly subsided.

POSITION OF THE FOURCHETTE IN COLOURED WOMEN.

DR. RAFAEL WEISS, writing in the *Revista de Ciencias Medicas* of Havana on the different position occupied by the vulva in white and coloured women, states that, according to his measurements, made on coloured multiparæ, the average distance from the coccyx to the fourchette is 5·6 centim., and that between the fourchette and the symphysis 6·8 centim., the anus and fourchette being 1·8 centim. apart. Comparing these with the measurements given by Föster for European multiparæ—viz., 7·2, 4·7, and 2·2 centim.,—it is evident that the vulva occupies a distinctly lower position amongst negresses than it does amongst Europeans. Dr. Weiss's own measurements of Europeans do not differ very widely from Föster's. A very low position he found quite exceptional amongst white women, while a very high one was not uncommon, the coxi-vulvar distance being in some cases as much as 8·6 centim. With women of unmixed negro blood, on the other hand, he never saw a case where the position was high, though it was sometimes so low that the fourchette occupied the position usually held by the anus in white subjects. The consequence of these differences is that in coloured women the period of perineal distention in parturition is much shorter and easier than amongst white women.

THE DONDERS MEMORIAL FUND.

THE subscription list from this country must, we are informed, be closed on Monday, May 14th, so it is necessary that intending subscribers should speedily send in their donations to the hon. secs., Messrs. Gerald Yeo and Brailey. Some £250 have already been subscribed here, while the total amount of the fund is estimated to exceed £2000. Donders' seventieth birthday is on Sunday, May 27th, but the celebration of it and the presentation to him of the fund is deferred to the following day. We hope shortly to announce the full programme of the day for the information of those of our countrymen who may be able to attend. It is certain that their presence in Utrecht would be much appreciated.

TOBACCO VERTIGO.

HAVING investigated sixty-three cases of excessive use of tobacco, Decaisne finds forty-nine to be over fifty years of age. More than half the cases presented, besides digestive derangements, alternating constipation and diarrhœa, an exaggeration of the urinary secretion and more or less abundant sweats, insomnia, and palpitation. In thirty-seven cases the smokers pursued the habit fasting, and in these vertigo was present especially in the morning. The appearance of the vertigo coincides in one-third of the cases with the suppression of the profuse sweats and marked diminution of the urinary secretion. Sometimes the vertiginous symptoms have been confounded with those due to cerebral congestion, and even to heart disease. Besides the absolute suppression of the use of tobacco, laxatives, warm baths, magnesia, and bitters are prescribed. Injections of ether subcutaneously also appeared to stop the vertigo in a few minutes.

THE PERIODIC LAW IN CHEMISTRY.

A VERY able paper on this law is contributed to the *Pharmaceutical Journal*, No. 930, by J. H. Worrall. The greater the heat evolved in the formation of a compound from its elements, the greater is the attraction between its atoms, and therefore the higher the melting point. Periodic properties were manifested in density, melting point, volatility, malleability, ductility and tenacity, electro-chemical power, oxidation, and so forth. The function of the atomic weights of the elements nearly all appear to vary periodically, and of the spectra of the elements it has been stated that the properties of the elements are a function of the wave lengths of their respective lines.

THE SIR GEORGE BURROWS MEMORIAL PORTRAIT.

WE are asked to state that the subscription list for this portrait will be closed on May 15th. Intending contributors are therefore requested to send their subscriptions without delay to any member of the committee, or to the hon. treasurer, Sir Dyce Duckworth, M.D., 11, Grafton-street, Piccadilly, W.

FOREIGN UNIVERSITY INTELLIGENCE.

Bologna.—Dr. Pedrazzoli has been recognised as *privat docent* in ophthalmology.

Breslau.—Dr. Ottomar Rosenbach, Chief Medical Officer in the Allerheiligen Hospital, has been promoted to the rank of Professor Extraordinarius.

Halle.—Dr. O. Rissel has been recognised as *privat docent* in Pharmacology.

Jena.—Dr. Engelhardt, of Halle, has been appointed Professor Extraordinarius of Gynæcology, in place of Professor Küstner, who has gone to Dorpat.

Königsberg.—Professor Lichtheim, of Berne, has accepted the invitation to take the post of Director of the Medical Clinic, in succession to Professor Naunyn, who has gone to Berlin.

Palermo.—Professor Silvestrini, of Parma, has been appointed Professor of Clinical Medicine.

Rome.—Dr. Gonella has been recognised as *privat docent* in Gynæcology.

DEATHS OF EMINENT FOREIGN MEDICAL MEN.

THE deaths of the following eminent foreign medical men are announced:—Professor Jos. Freiherr von Löschner, formerly of Prague, at the age of seventy-nine.—Professor Wroblevski, of Krakau, from blood-poisoning, due to an experiment performed in the lecture theatre.—Señor Don Antonio Casares, Professor of Chemistry and Rector of the University of Santiago, Spain.—Dr. Bourdel, *agregé* of the Faculty of Medicine, Montpellier.

THE Select Committee to whom the City of London Fire Inquests Bill was referred report that they have considered the measure, and have made amendments thereto. The Bill is confined to the City of London, though the notices required by the Standing Orders extended to the whole metropolitan area. As the local government of the metropolis is under the consideration of the House, the committee have not deemed it expedient to ask instructions for this wider extension of the Bill under present circumstances.

THE Queen has been pleased to direct letters patent to be passed under the Great Seal of the United Kingdom of Great Britain and Ireland granting the dignity of a Knight of the said United Kingdom unto John William Tyler, Esq., M.D., F.R.C.S., L.R.C.P., L.M., and L.S.A. (London), C.I.E.

FROM the report on the condition of the metropolitan water supply during the month of March by the water examiner appointed under the Metropolis Water Act, 1871, it appears that the Thames water, which throughout the greater part of the winter has contained only a very small amount of organic matter for river water, exhibited during the month a very marked increase in this respect. The water principally derived from the Lea, and supplied by the New River Company, also showed an increased proportion of organic matter, although the actual amount was much less than in any of the Thames waters. All the samples were clear and bright.

WE announced last week the subjects of the lectures to be delivered this year at the Royal College of Surgeons, with the names of the lecturers, but were unable to state the exact dates, which had not then been fixed. They are as follows: Mr. Barker will lecture on Monday, Wednesday, and Friday, June 4th, 6th, and 8th; Mr. Bryant on the corresponding days in the following week; and Mr. Marcus Gunn will deliver the Arris and Gale course on the 18th, 20th, and 22nd of the same month. Each lecture will commence at five o'clock P.M.

PALERMO, where for the last three months an epidemic of ulcero-gangrenous stomatitis has been raging (*vide* THE LANCET of Feb. 18th, p. 338), is now free from the disease, which has completely disappeared from the great lunatic asylum of the city, where it originated. The official report of the character, course, and treatment of the malady, shortly to be issued with the co-operation of the Palermitan sanitary inspector, is awaited with interest.

IN spite of all the therapeutic and hygienic measures which have for some time past been assiduously employed by the Dutch Government in order to combat the beri-beri or kakké disease, its ravages continue to increase, a Java newspaper stating that during the month of January no less than 1300 Dutch soldiers were invalided from Atchin with beri-beri.

ON the 29th ult. a dastardly attempt was made to blow up the Small-pox Hospital at Trooper's-hill, St. George, near Bristol. Fortunately the miscreants' want of knowledge of blasting prevented much damage being done to the building. It is stated that this is not the only attempt which has been made to destroy the hospital since its erection a short time ago.

THE Government of Victoria has instituted a Royal Commission to inquire into and report upon the sanitary condition of Melbourne. The list of members includes a president of the Central Board of Health, a vice-president of the Chamber of Commerce, some members of the Government of Victoria, a Government engineer, and two professors of Melbourne University.

As announced in our advertisement columns, the course of lectures at the Brompton Consumption Hospital will be opened by Dr. Mitchell Bruce—in place of Dr. Douglas Powell—on May 9th.

THE Italian War Office is about to establish, *en permanence*, at Massowah two officers with medico-chirurgical qualifications for the service of the reduced garrison on duty at that port.

THE annual dinner of the Pharmaceutical Society of Great Britain will be held at the Freemasons' Tavern on Wednesday, May 16th.

SMALL-POX AMONG SHEFFIELD TAILORS.

THE alarm felt throughout the north of England in consequence of the small-pox epidemic at Sheffield will not be decreased by the knowledge that this disease has broken out among various members of the tailoring trade. Fortunately for the public, the tailors' trade union has itself sought to supplement what is wanting in the law by providing compensation to those who cease work, so as to prevent the spread of epidemic disease. There are 205 journeymen tailors belonging to the Sheffield branch of the Amalgamated Tailors' Society, and, according to the rules of this association, any tailor suffering from an infectious disease receives 15*s.* a week to abstain from work. The temptation, therefore, to conceal the presence of infectious disease is not so great. During the last three months no less than seven members of the Sheffield branch have suffered from small-pox, and they received from the trade union funds £19 7*s.* 6*d.* to keep away from work. Thus, the public has been saved from a great danger, and the cost defrayed out of the funds collected from the hard earnings of the Sheffield tailors. But it is only the minority of tailors who are organised. Among those who work for sweaters there is no organisation. They have no sick fund to fall back upon; their earnings are generally too small to admit of any individual provision for a rainy day; and, when sickness comes, the family and as far as possible the invalid himself, are tempted to work all the harder, so as to find means to defray the cost of medicines &c. It is therefore natural to expect that the presence of infectious disease will be concealed as long as its revelation entails the ruin of the sufferers. If there have been seven cases of small-pox among the organised tailors of Sheffield, how many more cases must have occurred among the much larger number of tailors who are not organised. Have the local authorities been able to detect in good time each and all these cases? This is more than doubtful.

This position of affairs raises the whole question of compensation by the public authorities. When, some years ago, we published a report on the spread of diseases through laundries, we pointed out that it was impossible to expect that the extremely poor women who took in washing would break up their little business connexion by publicly declaring that infectious disease had broken out in the house where they washed their customers' clothes. The Chelsea Vestry, acting on this suggestion, did give compensation to some laundry women whose premises had been closed till after convalescence and disinfection. At Southport, in Lancashire, there has been some agitation on this question. Yielding to the influence of Mr. Threlfall, a working-man member of the Town Council, and others, compensation to the extent of £1 per week has been given in cases of infectious disease; but we are not aware that this example was followed to any extent elsewhere. Yet it must be realised that isolation and disinfection are enforced to the detriment of the individual for the protection and advantage of the community. For tailors, laundresses, and many other kindred industries, a declaration that small-pox or scarlet-fever exists on the premises involves little short of ruin. Still, it is the law of the land that concealment shall be punished; disinfection is compulsory, and no account is taken of the disastrous consequences that follow. If, for public convenience, a railway line is laid down or a new public road pierced through a crowded part of a town, the land and house owners are not only compelled to leave their property and habitations, but are compensated for the disturbance. So, also, with a tailor who is forced to abandon his trade for the time being, his individual interests are sacrificed for the public good, and the public owes him compensation. Nor is this merely a question of principle; it is a question of humanity, and it is, above all, a practical question. Whatever may be said of the theories and principles involved, in practice there will always be concealment of infectious disease unless fair compensation is given. The very poor and the very ignorant sections of the population, on whose condition the maintenance of public health in a large measure depends, will undoubtedly hesitate to declare at the first symptom that they fear one among them is sickening for some infectious disease so long as such a declaration involves heavy financial loss. The

tailors are to be congratulated on having taken this question in hand with so much zeal as to have actually given out of their private funds what might well be claimed from the public purse. But they only represent the aristocracy of labour. If every trades unionist in England followed their example this would only affect one-seventh of the working population. The question is one of such universal interest that it must be dealt with by those who represent not a society but the nation at large. It is a subject for legislation to decide whether, where the individual suffers for the sake of the entire community, he is not entitled to receive compensation from the public funds.

THE EXHIBITION OF THE ROYAL ACADEMY.

THE increasing number of Galleries for the exhibition of paintings now to be found in the metropolis, so far from lowering the standard of merit in each, as might possibly have been expected, appears, on the contrary, to have had the effect of raising it. It is probable that the Royal Academy never collected together so fine a show of works of art as that which is to be seen in Burlington House this year.

It is of great interest to note that the first work to be seen on entering the central hall of the Academy is that which probably stands out prominently as the finest in the Exhibition, and still more interesting that this is a piece of sculpture. The model of a statue of Her Majesty the Queen, erected at Winchester, which is contributed by Mr. Alfred Gilbert, the recently elected associate, is indeed a worthy specimen of the sculptor's art, not only on account of the power displayed in its design, but from the singular fidelity of the likeness and the dignity of the pose.

Of the pictures which will have peculiar interest to our profession, the Exhibition does not present so many as usual. What there are, however, are very good. Notably, the portrait of Sir William Jenner, by Mr. Holl, which was subscribed for by a numerous body of friends, is a remarkable success. It could not have been better, both as a likeness and in dignity of treatment. That of Sir Andrew Clark, by the same artist, is only second to it in merit. An admirable study of M. Pasteur, by M. Carolus-Duran, is to be found in Gallery No. 2. Mr. Symonds contributes a portrait of Sir William Aitken, presented to the Royal Victoria Hospital, Netley, by old pupils and friends.

Medical amateurs in art have not been so busy as usual this year, and we fail to find any contribution from Dr. Evershed. But there is a delightful etching, "Anchor-boat at Walberswick," which we are glad to welcome, from Dr. Gowers, the first, it is to be hoped, of a long series.

POOR LAW MEDICAL OFFICERS' ASSOCIATION.

AT a meeting of the Council of the Association, held at their rooms, 3, Bolt-court, Fleet-street, on May 1st, it was considered that the time had now arrived when Poor-law medical officers could co-operate most effectually in the proposed arrangement sought to be made by the medical officers of health.

It was proposed to suggest to the central authority that Poor-law medical officers should be styled "District health officers," and that their duties should include the acting as deputies to those appointed as health officers of counties or large districts.

The subject of the Public Health Prevention of Diseases Bill came also under consideration, and clause 3, sub-section 5, which makes a distinction in the amount of fees payable under different circumstances, was thought to be very objectionable and derogatory to those holding public appointments, and the Council requested Mr. Barnes to communicate its views upon this subject to Dr. Farquharson, M.P.

In reference to the Lord Chancellor's Coroners Bill, the Council resolved that it is not just towards the medical profession, and will in many cases be a hardship on the Poor-law medical service, if the appointment of coroners as proposed by the Bill becomes vested in the Lord Chancellor, and the Council urgently requests all members of the medical profession to oppose in every possible way that clause of the Bill which confers this power on the Lord Chancellor.

THE LOCAL GOVERNMENT BILL AND SANITARY ADMINISTRATION.

THE following letter has been received by Dr. Clifford Allbutt, in reply to a communication from that gentleman pointing out the defects in the new Local Government Bill, especially in reference to its provisions regarding the appointment, tenure, and duties of medical officers of health.

"DEAR DR. CLIFFORD ALLBUTT,—As you suppose, the quarter sessions did not find time to discuss the sanitary question. I think the adjourned session of May 8th will have to be adjourned again, as I believe the deputation to Mr. Ritchie will be later than that. I think that sanitary matters will fare worse under the Bill than they do at present, and I think medical men should raise an independent protest against Part III. (Sir Lyon Playfair has, I see, spoken on the second reading.) The proposal is that sanitary work shall be done by a District Council, which will be elected by the cottagers in rural sanitary districts, divided into wards for the purpose of election of one councillor. Practically speaking, all ratepayers rated above £4 per annum will thus be disfranchised, as they will have a vast majority of smaller ratepayers to outweigh them. I do not think it would be possible to have a more ignorant council than that which will probably result from this proposal, and I should think that vaccination and all compulsory sanitation will in most cases be opposed by them. It is these clauses to which, in my opinion, public attention should be directed. The powers of the County Council can be increased after they have come into action.

"Yours very truly,

"W. SPENCER STANHOPE.

"Cannon Hall, Barnsley, April 24th."

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

IN twenty-eight of the largest English towns 5781 births and 3400 deaths were registered during the week ending April 28th. The annual rate of mortality in these towns, which had been 21·9 and 19·9 per 1000 in the preceding two weeks, further declined last week to 18·9, and was lower than in any previous week since the middle of October last. During the first four weeks of the current quarter the death-rate in these towns averaged 20·2 per 1000, and was 2·7 below the mean rate in the corresponding periods of the ten years 1878-87. The lowest rates in these towns last week were 14·7 in Hull and in Bolton, and 16·1 in Newcastle-upon-Tyne and in Brighton. The rates in the other towns ranged upwards to 23·5 in Leicester, 24·3 in Wolverhampton, 24·8 in Manchester, and 25·9 in Blackburn. The deaths referred to the principal zymotic diseases, which had been 358 and 364 in the previous two weeks, declined last week to 328; they included 143 from whooping-cough, 48 from scarlet fever, 38 from measles, 35 from diphtheria, 34 from diarrhœa, 23 from "fever" (principally enteric), and only 7 from small-pox. No death from any of these zymotic diseases was registered last week in Preston or in Birkenhead; whereas they caused the highest death-rates in Manchester, Salford, Oldham, and Cardiff. The greatest mortality from whooping-cough occurred in Wolverhampton, Manchester, and Salford; from scarlet fever in Oldham, Blackburn, and Cardiff; from measles in Bradford, Leicester, and Bristol; and from "fever" in Leicester. The 35 deaths from diphtheria included 22 in London, 3 in Oldham, 2 in Huddersfield, 2 in Sheffield, and 2 in Newcastle-upon-Tyne. Small-pox caused 5 deaths in Sheffield, 1 in London, and 1 in Bristol, but not one in any of the twenty-five other large provincial towns. The Metropolitan Asylum Hospitals contained 21 small-pox patients at the end of the week, against 8, 15, and 21 on the preceding three Saturdays; the Highgate Small-pox Hospital contained 3 patients at the end of the week. The number of scarlet fever patients in the Metropolitan Asylum Hospitals and in the London Fever Hospital was 1047 on Saturday last, against numbers decli-

ing steadily in the preceding twenty-one weeks from 2764 to 1045; the 89 cases admitted to these hospitals during the week showed a decline of 16 from the number in the previous week. The deaths referred to diseases of the respiratory organs in London, which had been 444 and 363 in the preceding two weeks, further declined last week to 343, and were 41 below the corrected average. The causes of 68, or 2·0 per cent., of the deaths in the twenty-eight towns last week were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Sunderland, Brighton, Bolton, and in three other smaller towns; the largest proportions of uncertified deaths were registered in Halifax, Hull, and Liverpool.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had been 20·8 and 21·2 per 1000 in the preceding two weeks, was 21·0 in the week ending April 28th; this rate exceeded by 2·1 the mean rate during the same week in the twenty-eight large English towns. The rates in the Scotch towns ranged from 14·9 and 16·1 in Greenock and Aberdeen, to 24·3 in Glasgow and 32·0 in Paisley. The 530 deaths in the eight towns showed a decline of 5 from the number returned in the previous week, and included 17 which were referred to whooping-cough, 12 to diarrhœa, 8 to measles, 5 to diphtheria, 4 to scarlet fever, 3 to "fever" (typhus, enteric, or ill-defined), and not one to small-pox; in all, 49 deaths resulted from these principal zymotic diseases, against 49 and 62 in the preceding two weeks. These 49 deaths were equal to an annual rate of 1·9 per 1000, which exceeded by 0·1 the mean rate last week from the same diseases in the twenty-eight English towns. The fatal cases of whooping-cough, which had been 26, 20, and 17 in the previous three weeks, were again 17 last week, of which 9 occurred in Glasgow, 3 in Edinburgh, and 2 in Aberdeen. The 12 deaths attributed to diarrhœa showed a further increase upon recent weekly numbers, and were 4 above the number returned in the corresponding week of last year. The 8 fatal cases of measles, which were within 1 of the number in the previous week, included 6 in Glasgow; while the 5 deaths from diphtheria showed a decline of 6, 4 being recorded in Glasgow. The 3 deaths referred to "fever" and the 4 to scarlet fever corresponded with the numbers in the previous week; all the 3 deaths from "fever" were returned in Glasgow. The deaths referred to acute diseases of the respiratory organs in the eight towns, which had declined in the preceding four weeks from 144 to 122, further declined last week to 109, and were 2 below the number in the corresponding week of last year. The causes of 61, or more than 11 per cent., of the deaths registered in the eight towns during the week were not certified.

HEALTH OF DUBLIN.

The rate of mortality in Dublin, which had declined in the preceding four weeks from 31·2 to 24·8, rose again to 31·5 in the week ending April 28th. During the first four weeks of the current quarter the death-rate in the city averaged 27·9 per 1000, the mean rate during the same period being 19·1 in London and 20·3 in Edinburgh. The 213 deaths in Dublin showed an increase of 45 upon the number in the previous week; they included 7 which were referred to scarlet fever, 5 to "fever," 5 to whooping-cough, 3 to measles, 1 to diphtheria, and not one either to small-pox or diarrhœa; in all, 21 deaths resulted from these principal zymotic diseases, against 19, 15, and 12 in the preceding three weeks. The annual death-rate from these zymotic diseases was equal to 3·1 per 1000, the rate from the same diseases being 1·9 in London and 1·4 in Edinburgh. The fatal cases of scarlet fever, which had been 1 and 3 in the preceding two weeks, rose last week to 7, and exceeded the number in any previous week since the middle of February. The deaths from "fever" and from measles also exceeded the numbers returned in the previous week; while the fatal cases of whooping-cough and diphtheria showed no variation. The deaths of infants exceeded the numbers in recent weeks, while those of elderly persons corresponded with the number in the previous week. Six inquest cases and 3 deaths from violence were registered; and 73, or more than a third, of the deaths occurred in public institutions. The causes of 17, or 8 per cent., of the deaths in the city were not certified.

Correspondence.

"Audi alteram partem."

DISINFECTION OF HOSPITALS FOR THE TREATMENT OF INFECTIOUS DISEASES.

To the Editors of THE LANCET.

SIRS,—I would not venture to trouble you with any communication on the subject of the disinfection of buildings used for the treatment of infectious cases were it not for the fact that the consensus of opinion appears to be somewhat divided; hence I take it that the practical results obtained by those who for any length of time have been associated with the Metropolitan Asylums Board are, or should be at least, valuable.

In your issue of April 21st, Dr. Collie mentions the outcome of the plans recently employed in connexion with a wooden building at Homerton. With your permission I will supplement this by briefly recording what has passed under my own observation during the past few years. In October, 1874, I had received 1695 cases of small-pox into the Homerton Small-pox Hospital from the date of its opening in 1871, it then becoming necessary that scarlet fever patients should be admitted. Preparations were accordingly made for their treatment; 122 of this class passed through the wards without any case of small-pox arising. Again, on Oct. 22nd, 1875, scarlet fever patients were admitted, 49 in all, without small-pox appearing. No case however, of variola had been admitted meanwhile. On June 22nd, 1876, the reception of small-pox patients was recommenced, 620 being treated during the year without scarlet fever being seen amongst them. In 1877, 1935 persons suffering from small-pox were admitted, and in 1878, 964. On March 15th, 1879 enteric cases were received, the total number being 154. Among these a case occurred of undoubted small-pox. This man, however, was transferred from another hospital on Sept. 29th, the eruption appearing on Oct. 12th. Reckoning the day of admission and the day he was isolated, we have a period of exactly fourteen days. He might therefore have contracted the disease in either the one or the other hospital, and it must always remain a matter of uncertainty as to which should be credited with the source of infection. In May, 1881, it was decided to establish a temporary camp hospital at Darenth, owing to the want of accommodation for small-pox patients in the London hospitals. Between this date and the early part of the following year 2104 passed through the camp. The whole of this number had their meals served in the refectory situated in the main asylum building, which had hitherto not been occupied. The reasonable conclusion was that this part of the institution, not utilised only for the purpose to which I have just alluded, but also as sleeping accommodation for the whole of the staff, must have become fairly well infected; little surprise can therefore exist for my grave anxiety as to whether or not small-pox would show itself when adult imbeciles, for whom this building was expressly erected, should become located there. As a fact, however, I believe I am justified in stating that not a single case has since arisen, and each block (two in number) has now for six years or thereabouts had a daily population of 100. In this case also I may fairly conclude that the disinfection was complete and perfect. Coming to 1884—another small-pox epidemic period,—it was considered necessary to make provision here for persons suffering from this class of disease, the total number treated being 781. At the expiration of this time the wards constructed entirely of wood were subjected to my usual plan of disinfection, and have since been filled with scarlet fever patients, without, however, any cases of small-pox arising; indeed, we were yet more venturesome, for beyond destroying books, mats, and so forth, the same beds, clothings, and articles of furniture have since been freely made use of. Very heartily I endorse Dr. Collie's conclusions as regards the value of "wind and weather," but I hesitate in being satisfied with these even when supplemented by the free use of soap and water. Dr. Collie's experience and mine are, I know, very similar, and the results attained are, I have reason to believe, equally satisfactory; therefore a less amount of labour would appear to

be productive of the same ends. The plan, however, I have invariably adopted is to fumigate *very freely* with chlorine, then wash all woodwork with carbolic soap, expose to "wind and weather" for at least a week, and finally complete the proceeding by a second fumigation of chlorine. Furniture has always been treated by washing with a solution of carbolic acid and placing the articles when completed in the open air, but woollen and linen articles, and feathers (a hospital abomination), have been passed through a Lyon's disinfector, the value of which cannot, I suppose, be over-rated; exposure to a current of steam, at a temperature of 212° F., being found to be a far more satisfactory plan than the use of dry heat, involving less injury to blankets &c.; it is also more simple, more rapid, and I believe more certain in its action. As regards the question of the relative value of wooden and brick wards, all things being equal, one would, I presume, show a preference for the latter, for a variety of reasons; but, after a somewhat extended experience of both, I cannot but conclude that *properly* constructed wooden huts, of which we have several in use at the present time here, leave little or nothing to be desired; through the whole of the past severe winter there has never been the slightest difficulty in keeping a temperature of 50° F., abundant ventilation notwithstanding, this being obtained by means of slow combustion stoves, fed with a combination of large coals and screenings; but whether a desirable degree of coolness can be maintained in the summer months remains to be proved. Hitherto, in some old buildings constructed upon similar principles, I will admit that the heat has been more than desirable, but not so embarrassing as hinted at by some of your correspondents.

I am, Sirs, yours faithfully,

W. GAYTON, M.D.

Metropolitan Asylum Board, North-Western Fever Hospital, Haverstock-hill, N.W., April 25th, 1888.

To the Editors of THE LANCET.

SIRS,—Although I cannot lay claim to the ripe experience with which Dr. Seaton in his letter in your issue of April 14th justly credits Dr. Collie, yet the result of some eight years' observation as to the efficacy of disinfecting permanent infectious wards may perhaps be worth adducing. The wards of this hospital, the walls of which consist partly of brick piers and partly of corrugated iron lined by felt and matchboard (in that order from without inwards), have over and over again been used, after disinfection, successively for smallpox and for febrile diseases of various kinds—e.g., scarlet fever, measles, diphtheria, enteric, &c. In no case whatever has the preceding disease affected the new occupants of the ward. Our plan consists in free fumigation by nitrous fumes (produced by the action of nitric acid on copper filings), followed by thorough cleansing with carbolic soap and water of all wood and iron work, and by distempering the brick portion of the wall of the ward.

I am, Sirs, yours faithfully,

R. D. R. SWEETING,
Medical Superintendent.

Western Fever Hospital, Fulham, April 18th, 1888.

"ANOREXIA NERVOSA."

To the Editors of THE LANCET.

SIRS,—Discussion being invited, may I ask space for a few words? I have seen a considerable number of cases, and I believe that this is a distinct form of disease, having its seat in the nerves of the stomach; that its name is nosologically correct; and that Sir Wm. Gull's treatment is all that is required for its cure. It has nothing to do with neurasthenia. This, I think, is proved by the fact that here the patient neither eats nor drinks, but walks—is constantly on the "go"; whereas in neurasthenia the patient eats and drinks, often in great excess, but does not and cannot walk. Dr. Playfair evidently looks on anorexia nervosa as secondary to some general nervous disturbance, and advises all cases to be dealt with as in true neurasthenia—with absolute rest, stuffing, massage, and isolation. Dr. Playfair goes so far as to say that Sir Wm. Gull's case was cured by a "fluke" (a happy chance), and he asserts that not one case in twenty could be so cured. All I can say is, I have never failed ultimately in seeing health established in every case of anorexia nervosa without isolation, and, above all, without the aid of that most fashionable, and in a very great number of cases most unnecessary, though systematic, piece of humbug—massage. I allude to the "knotted muscles," "the blocked vessels," "contracted sinews," "thickened nerves and oilless joints," so readily discovered by the fingers of both male and female rubbers. Besides, isolation means a lot of money; it is not everyone who can afford to enter a so-called "home" and purchase health according to its tariff. I quite agree with Dr. Playfair that for the "hardened neurotic sinner" removal from the usual and, above all, unwholesome domestic surroundings is essential; but the subject of nervous dyspepsia is more sinned against than sinning, and can be cured without imprisonment.

I am, Sirs, yours truly,

A. S. MYRTLE, M.D.

Harrogate, April 28th, 1888.

PHTHISIS.

To the Editors of THE LANCET.

SIRS,—Although I think your readers have every reason for thanking Dr. Shepherd for his suggestive and helpful article on phthisis, yet I do not think it ought to pass without some word of criticism.

If Dr. Shepherd had said that "cold air breathed at night" is *often* the starting point of phthisis, he would have taken what I conceive to be an impregnable position, but he has stated it to be so in the *vast majority* of cases. Now, Dr. Buchanan, in his report "On the Distribution of Phthisis as affected by Dampness of Soil," came to the conclusion—which, I believe, has never yet been authoratively contradicted—that in many places the drainage of the subsoil had reduced the phthisis death-rate in a very marked manner—49 per cent. at Salisbury, 47 per cent. at Ely. The drainage of the subsoil must tend to the diminution of watery vapour in the air lying above it, and this watery vapour tends to prevent the escape of radiation of heat rays of low refrangibility. Hence any cause which removes watery vapour tends to increase the difference between day and night temperatures; and therefore surely, if Dr. Shepherd is right, and the whole truth is stated in his propositions, should it not follow that the drainage of the subsoil should increase the phthisis mortality? I think this line of argument is conclusive that the other factors of the question are too important to be put aside even for a time.

I am, Sirs, yours faithfully,

ADOLPHUS J. RICHARDSON, M.B.

St. John's-terrace, Hove, March 30th, 1888.

THE VICTORIA UNIVERSITY.

To the Editors of THE LANCET.

SIRS,—I was pleased to see from your Manchester correspondent's communication that an increasing number of students are availing themselves of the opportunities of taking the medical degrees of the Victoria University. I wish it were as he suggests in his letter to you, for then I should believe that this University was fulfilling a useful function for the northern counties, and that it was affording opportunities to our youths which they have been compelled hitherto to seek across the border. The fact is, the University authorities are seeking to make their degree equal to that of the London University, which, in my humble opinion, would make it prohibitive for the young men of these districts who are to be the ordinary practitioners in future years; besides, being a new university, the Victoria does not and cannot possess the prestige of the London.

I was in hopes that when the Victoria University got permission to grant degrees in medicine, and became the twentieth licensing body, it would have had a standard not inferior to Durham or the Scotch Universities, and that in future the students of Manchester and Liverpool would have an opportunity of obtaining a degree in medicine after a fair standard of examination, and not be compelled to migrate northwards to obtain what they ought to have at their own doors. These hopes, however, for the present at any rate, appear doomed to disappointment. If the degrees in Victoria are to be simply higher degrees in medicine and surgery, then it would be well for this to be more generally understood, and parents would be able to make arrangements for the education of their sons at places where they would have a chance of graduation.

To show that such opportunities are not presented at either Manchester or Liverpool, I would call attention to

the pass list of Victoria University in March last. Manchester probably has 300 medical students on its books, and we find six Owens men and three Liverpool men on the list of successful candidates for the Intermediate M.B.; for Part I., Final, seven from Owens and one from Liverpool; for Part II., Final, we have one from Owens in the second division. So that we have a University situated in a large centre having three affiliated colleges, with *one* admission to the M.B. degree; this successful candidate, I believe, is an F.R.C.S. Eng., and attains the distinction of M.B. Victoria in the second division.

The Supplemental Charter was granted to Victoria University on March 20th, 1883. Since that time not twenty M.B.'s have been admitted. The medical commission appointed in 1881 recommended "that the Victoria University should, in respect of medical degrees, be placed without delay on the same footing as the older universities," and this University has so far fulfilled its obligations as to grant about ten M.B. degrees in five years. Now, why should these difficulties be thrown before the youths of Manchester, Liverpool and surrounding towns? Are not the standards of Aberdeen, Edinburgh, Glasgow, Durham, and the Royal University of Ireland sufficient for the ordinary practitioner? We cannot all be professors, nor yet can we all afford the time and money to undergo a prolonged curriculum and obtain a degree higher from an examination point of view than the universities mentioned.

I am a general practitioner, and have had to do with the training of pupils. When the parents of a young man ask where they should send their sons to study, or a young man asks me what degree I would advise him to seek, I am compelled first to advise him to get a degree in medicine; and next, under the existing circumstances, to advise Edinburgh or Glasgow. Now, why all this, when we have the colleges and the necessary teaching staff at our very door? Lately, the Victoria University obtained a grant of £2000 per year out of the consolidated fund to pay its examiners (and I am informed the professorial examiners receive no fee); and the University was successful in its application, because of the assistance it obtained from the corporations of the surrounding towns. Surely the inhabitants of these towns have a right to expect something in return.

I am sure the University authorities are not aware that their examinations are of such a nature as to make it absolutely prohibitive for the ordinary student, and are thus inflicting a great hardship on the parents and youths in the surrounding districts. The Universities of Edinburgh, Glasgow, and Aberdeen recognise the requirements of the young men in Scotland, and make their degrees attainable to the average student, placing those who have abilities in honours classes; whereas the degrees of Victoria University, so far as medicine is concerned, are honours degrees.

I am, Sirs, yours truly,

Wigan, April 16th, 1888. WM. BERRY, F.R.C.S.I.

OUR UNPROTECTED NURSES.

To the Editors of THE LANCET.

SIRS,—In view of a threatened epidemic of small-pox, I venture to address you upon a subject which has long been a matter of considerable surprise to me; I allude to the unprotected condition of the nurses in the great hospitals of the metropolis as regards small-pox. It is rarely that a year passes without my having to admit hospital nurses suffering from small-pox, and, upon inquiry, I find, more often than not, that these nurses have not been vaccinated since infancy. The Government rightly insists upon the revaccination of its servants, whether in the army, the police, or the postal telegraph service, and surely, Sirs, it is a reproach to us as medical men that we do not represent to the governing bodies of these hospitals the urgent necessity of similarly protecting their servants, who are so frequently exposed, from the nature of their duties, to the infection of variola. I am, Sirs, yours obediently,

HERBERT GOUDE, M.D.

Small-pox and Vaccination Hospital, Highgate-hill, Upper Holloway, N., April 30th, 1888.

DOMESTIC HYGIENE.—On May 5th (this day), at 3 P.M., the Duchess of Albany will distribute the certificates to ladies who have passed the examination following the lectures on Domestic Hygiene delivered by Dr. A. T. Schofield at the Parkes Museum.

MANCHESTER.

(*From our own Correspondent.*)

INSANITARY WORKSHOPS IN MANCHESTER.

YOUR special article of the 21st ult. exposing the insanitary conditions &c. of the "sweating dens" of our city has attracted considerable attention here both in the local press and in the public mind, and some rather searching criticisms have been passed upon the health department of the corporation for permitting such a condition of things to exist. It has been stated that the oversight and control of workshops is placed in the hands of the factory inspectors, but the health authorities have ample powers to at once abate and forbid the existence of such ordinary common nuisances as those exposed by your commissioner. On the same date that your article appeared, one of our newspapers had a very strongly written "editorial" upon the continued high death-rate of Manchester, which stands above all other English towns. The *Health Journal* (which, by the way, ceases to exist after this month) also in its last issue commented on the same subject, and attributed much of it to "pollution of air, of water, and soil," to which might be added pollutions of dwellings. Thousands of dwelling-houses exist in the city, which only by a very great stretch of imagination can be described as fit for human beings to live in, and by those familiar with the habits of the densely crowded population of these insanitary houses little astonishment is felt at the high mortality amongst the infants and young children of those districts. The corporation has made a beginning in demolishing some of the worst of these wretched houses, but much remains to be done before any definite results can be observed therefrom. Many of our local sanitarians have time after time directed attention to this matter as well as our Sanitary Association, which has at the present time the subject under its special consideration. Even at the last meeting of the Board of Guardians the same topic cropped up, and it was decided that the officials of the board should report in writing the exact localities where the worst dwellings existed as they came across them in their daily work.

A lecture on the "Effect of Air-pollution on Plant Life," delivered recently by Mr. Robert Holland, consulting botanist to the Royal Manchester and Liverpool Agricultural Society, formed the last of the present series given under the auspices of the Noxious Vapours Abatement Association, and was a fitting corollary to the one lately given by Dr. Simpson; but at present all these efforts are but like the voice of one crying in the wilderness, so far as any improvement of our murky atmosphere is concerned.

THE ASSIZES

At the assizes now being held two cases may be mentioned in these columns. One, a case of murder, has resulted in the sentencing to death of the prisoner, a young man who on March 1st brutally killed a woman with an axe and attacked a daughter of the woman with the same weapon in so violent a manner as to endanger her life, but under treatment in the infirmary wards the latter had recovered. There were no mitigating circumstances whatever in this cold-blooded murder. In the second case, a gang of men who have for some time past been pursuing the trade of quack doctors, pretending to cure and prevent certain diseases, were convicted and sentenced to terms of imprisonment with hard labour. The three principal culprits pleaded guilty, and two others were formally found "Not guilty," as the prosecuting counsel, with the consent of his lordship, Mr. Justice Charles, decided it was better, in the interest of public decency and morals, not to lay bare all the details connected with the prisoners' nefarious transactions. Their operations had extended far and wide to persons of all ages and apparently of all positions, as some of the victims had been mulcted to the tune of no less than £190.

MEDICO-ETHICAL SOCIETY.

At the last meeting of the Medico-Ethical Society held on Friday night, and which was principally of a social character, Mr. J. Broadbent, who for more than ten years has been the hon. secretary to the Society, was presented with a very handsome illuminated address, as an acknowledgment by the members of the time and labour he has devoted to their interest. Dr. H. Simpson, the President, in presenting the address, conveyed the thanks of the members to Mr.

Broadbent for all he had done to promote the welfare of the Society.

HIGH SHERIFF FOR LANCASHIRE.

Few men in Manchester are better known in all philanthropic matters and movements connected with the well-being of the public at large than Mr. Oliver Heywood. In him most of our local medical charities find a liberal supporter, and in more than one—notably the Children's Hospital, Pendlebury—he has been much more than a subscriber of money. His appointment this year to the office of high sheriff has afforded an opportunity for all sorts and conditions of men to do him honour, and the corporation have, at a public banquet, conferred upon him the freedom of the city.

LIVERPOOL.

(From our own Correspondent.)

THE HOSPITAL FOR WOMEN.

BY the kind permission of Mr. D'Oyley Carte a performance of the favourite Gilbert-Sullivan comic opera, "The Sorcerer," was given last evening in St. George's Hall, by the Rock Ferry Amateur Operatic Society, in aid of the funds of the Hospital for Women. The performance was in all respects a most brilliant success, not the least being that a considerable sum will be handed over to the treasurer of the hospital as the net proceeds.

A FEMALE CANCER CURER.

An inquest was held on the 30th ult. by the city coroner on the body of a man, aged forty-nine, who had for some time past been the subject of cancer in the cheek. He was first treated by a chemist, next at the Cancer Hospital and Royal Infirmary, then under a private practitioner (Dr. Steele), and for some weeks before his death he appears to have been under the care of a Mrs. Margaret Stewart, a widow and herbalist. From the evidence of this woman it appeared that she derived her knowledge of herbs from her mother, but supplemented it by subsequent study. She gave the deceased a mixture to correct his stomach and liver in order that he might be able to take nourishment, and a salve to apply externally to cleanse the canker (!) away from his cheek. Dr. Steele informed the court that the cause of death was hæmorrhage from the cheek, one of the small arteries having given way. Humanly speaking, the deceased should have lived for fifteen months or two years. The disease had spread very rapidly, and he condemned both the internal and external treatment. The jury returned an open verdict, censuring the wife for not obtaining medical advice, and cautioning the herbalist against treating such cases.

HOSPITAL SATURDAY.

Next Saturday is the date agreed upon for the annual Saturday collection from working men on behalf of the local hospitals. Very strong efforts are being made to ensure greater success than has previously attended this movement, working men of Liverpool having fallen considerably short of their fellow working men in Glasgow and Birmingham.

THE ISLE OF MAN.

The many advantages of the Isle of Man as a health resort are too well known to need description. It is very satisfactory to learn that the same facilities of access to the island which gave so much satisfaction last year will be continued on and after the 17th inst. There will be daily services by the steamers both of the new and old companies, the passage from Liverpool occupying from four to five hours, though this has been considerably shortened on some occasions. Every consideration will be shown for the comfort of the passengers, and the rates of passage will be on the same reduced scale. For those to whom a short sea voyage and a bracing atmosphere are beneficial the Isle of Man offers peculiar advantages.

Liverpool, May 2nd.

ROYAL SOUTH HANTS INFIRMARY.—Last week the Mayor, Mr. Ald. Coles, in the presence of a large assembly, laid the foundation stone of the out-patients' wing of this institution, subscribed for as a memorial of the Queen's Jubilee. The site of the new building is in the rear of the infirmary.

NORTHERN COUNTIES NOTES.

(From our own Correspondent.)

NEWCASTLE.

I MENTIONED last week the low rate of mortality prevalent at Sunderland. That of Newcastle this week is exceptionally low—viz., 16 per 1000, which, I believe, is the lowest rate noted since November 1886.—Mr. J. R. Milburn of this city has patented some electric lamps suitable for miners and general purposes, and it is claimed for the light that it is continuous, of low cost, and of little weight. He shows that for miners it is cheaper and safer than the ordinary oil-lamp, and will also be cheaper than gas where the cost of the latter is more than 2*s.* 6*d.* per 1000 feet. The arrangement of the battery appears much similar to others. The fluid element is the patent; it can be made odourless, but in the case of miners' lamps the odour is preferred, as it has a tendency to neutralise other gases which are dangerous.—Great vigilance will be necessary to keep small-pox out of our north country ports. For instance, a steamer arrived in the Tyne the other day, and she reported that a man taken on board at a Spanish port had been attacked four days after sailing. Afterwards two of the crew were seized with the disease. The captain bore up for Portland, flying the quarantine flag. The medical officer of that port came on board, and they were removed to hospital.—Dr. Richard Brown of Blaydon has received a presentation and address, having conducted a very successful ambulance class. Colonel Cowen, who presided, remarked that a little knowledge of ambulance work was a very useful thing, and had it not been for the knowledge of one of the class, a policeman who met with an accident on the waggon way at Stargate would not now be alive.

WHOLESALE ADULTERATION OF HOSPITAL MILK.

Last week a farmer and milk contractor was fined for selling adulterated milk. It was proved that he had supplied milk with 11 per cent. of added water to the Durham County Lunatic Asylum at Sedgefield, and, as the defendant supplied the asylum with 138 gallons of milk a week, it was rather a serious thing, for it was shown that the contractor would be paid weekly for about fourteen gallons of water supplied instead of milk. He pleaded that it was done without his knowledge by his servants.

BRAVERY OF A MEDICAL MAN.

Among the many heroic explorers after the late sad explosion at Workington, the name of Dr. Omrod should not be forgotten. At a late public meeting at Workington a leading speaker, in moving a resolution, thus spoke of Dr. Omrod's services. After alluding to the accident in feeling terms, he said "he had got the names of those who first entered the pit, and said a medal should be struck for them and Dr. Omrod. A man named Linton, an explorer, missed a workman explorer named Tinnion, who had fallen behind from the effects of the afterdamp. Linton wished to go back for him, and asked who would go with him. No one replied, and then he said he would go himself. Then Dr. Omrod put his arm through his, and said he would go with him; and, with a bottle of brandy in his hand, and Linton with a lamp, together they went back about 300 yards, where they found Tinnion staggering about like a drunken man. They got him back to the shaft, and he was saved.

DEATH OF DR. PEARSON OF MARYPORT.

I regret to mention the death of Dr. Pearson of Maryport, which took place at his residence on Saturday, the 21st ult. He was sixty-six years of age, and was the son of the late Robert Pearson of Great Orton, Carlisle. Dr. Pearson studied at Edinburgh, where he took his degree in 1864. He published an important paper jointly with the late Dr. Curtis on "Poisoning with Lobelia," and a further able paper on "Experiments on the Poisonous Properties of Lobelia Inflata." He was an officer under the Cockermouth Union for the long period of thirty-seven years. About seven years ago he met with a serious accident while driving, and since then he had been gradually retiring, the harder work devolving on a partner. He enjoyed a very large practice, being medical adviser to most of the leading families in the town and district. Dr. Pearson was appointed a justice of the peace in 1883.

Newcastle-on-Tyne, May 1st.

EDINBURGH.

(From our own Correspondent.)

THE SUMMER SESSION.

THE work of the medical classes in the University and the Extra-mural Medical School was resumed last Tuesday. In several departments introductory addresses were delivered, notably in those of Botany and Physiology. In commencing his summer course of Practical Physiology, Professor Rutherford referred to his recent absence for several months on account of ill health. In commencing the work of a new session, he expressed his gratification at the cordial manner in which his hearers received him once more into their midst. He was pleased to be able to tell them that his sojourn in a genial southern climate had completely restored his health. He could not, however, proceed with the work of the day without giving public expression to his gratitude to Professor Haycraft, who in his enforced absence had conducted the duties of the chair with signal ability and success. Dr. Rutherford then delivered an address on the importance of a practical scientific training in connexion with medical work, and pointed out in how many particulars the work of the practical course is invaluable as an aid to exact diagnosis in conditions of health and of disease.

THE NEW PROFESSOR OF BOTANY.

The rigours of an eight o'clock lecture hour were pretermitted on the first day of the session, and Professor Bayley Balfour was formally inducted into the duties of his chair at the more comfortable period of 3 P.M. The large new lecture hall at the Botanical Gardens was crowded to overflowing some time before the hour of meeting, and when the new Professor appeared, introduced by the Principal, Sir W. Muir, and supported by a large contingent of his colleagues in the Senatus, he received quite an ovation from the enthusiastic audience that had assembled to hear his inaugural address. When at length he found an opening for speech, he referred in well-chosen and sympathetic terms to the career of his intimate friend and predecessor, the late Professor Dickson; deploring its sudden and untimely termination at a time when its long and useful continuation might apparently have been so certainly looked for. No less pleasing was his reference to the memory of his late father, Professor John Hutton Balfour, who for thirty-four years had occupied the post of honour and responsibility in which he now found himself. Referring to the position of botanical studies in the medical curriculum, he found himself an unflinching apologist for the present system, which makes botany so important a prelude to the more specialised work of the study of medicine. A glance at the history of medicine showed how this had come about; and a little closer inspection of the necessary steps in a scientific training gave conclusive evidence why such a system must be continued in the interests of a sound academic curriculum. Referring to the "Botany Clause" in the Universities Bill, he did not hesitate to describe the projected transference of the Gardens from the Crown to the University as alike inexpedient and impolitic, since it was only an apparent, not a real, boon to the University, while it deprived the public of their most charming park and recreation ground. He strongly urged the omission of this clause, which is not an integral part of the Bill, and the removal of which would in no way lessen the value of that useful measure of reform. Professor Balfour was attentively listened to, and held the interest of his audience closely, even in those parts of his address that do not appeal specially to the imaginations of first-year students.

Mr. Patrick Geddes, F.R.S.E., recently a candidate for the chair of Botany in the University of Edinburgh, has been appointed Lecturer on Botany in University College, Dundee, where he is now delivering a summer course of lectures. Mr. Geddes was trained as a teacher and investigator in London, under Professor Huxley and others, and has had a long and successful career as a teacher in Edinburgh as assistant to the late Professor Dickson. His biological and botanical writings are widely known.

Edinburgh, May 2nd.

THE Court of Common Council last week voted £105 to the Middlesex Hospital, £52 10s. to the City Orthopædic Hospital, and £105 to the Asylum for Idiots.

GLASGOW.

(From our own Correspondent.)

THE HENDON COW DISEASE IN GLASGOW.

DR. J. B. RUSSELL furnishes a most interesting report on an outbreak of scarlet fever in the Garnethill District of Glasgow, associated probably with a cow disease resembling that recently found at Hendon. Putting the matter briefly, there were found in the above-named district, after a house-to-house inquiry, 96 cases of scarlet fever and sore throat; 1473 families were visited; 172 of these families were supplied with milk from the suspected dairy, and among them 95 out of the 96 cases were discovered; the remaining 1301 families had their milk from other sources, and yielded only one case of the fever. This seems to establish the fact that infected milk from that particular dairy was the medium through which the disease was distributed. The milk was further traced from the dairy to a particular farm at which there had been scarlet fever. The epidemic began in Garnethill on March 15th, and from that date cases sprang up day by day. At the farm referred to, the son of the farmer, who drove the milk to town, was seized on March 23rd, and a byreman on March 24th. The question then arose, "Did the milk derive its infection from the cows?" as in the Hendon case in 1886. To settle this point, the stock was carefully inspected. Dr. Russell's report here goes on to state that "the only change in the stock had been the purchase of one cow on Feb. 21st, and of three cows on March 7th. These were all in the quarantine byre. One of the cows bought on March 7th was very thin and 'mangy-looking.' The teats had several sores covered with bloody scabs. Of the two cows bought at the same time, one was quite sound, the other had a small scab on one teat; both were in good condition generally. The other cow, bought Feb. 22nd, was in good condition, not casting hair, but had similar scabbed sores on the teats, bleeding readily. Mr. M'Call thought those two cattle should be removed to the Veterinary College for observation, a proposal to which the farmer gave ready consent, and they were transferred on March 31st. Here Mr. M'Call and his staff, with Dr. Carmichael, Mr. Maylard, and myself, have had them under observation. A calf fed on this milk was almost at once seized with a highly febrile illness, which nearly killed it, but from which it is now recovering with loss of hair and copious casting of the skin. The cow which was not casting hair or skin when removed is now doing so freely." The local authority has purchased the cows referred to in the report, and kept them for observation.

HEALTH OF THE CITY: A GLASGOW "WIGWAM."

The death-rate in the city during the last fortnight was 24, as against 25, 25, and 28 in the three preceding years. One case of small-pox had been registered—a man who left Sheffield on April 1st and remained in Edinburgh till the 8th, when he came to Glasgow. The case is a very mild one, and it is thus all the more gratifying that it was promptly recognised and removed. There is a slight revival of typhus, but in new localities. The most remarkable example of the conditions which maintain this disease in our midst is afforded by a one-apartment house, measuring 1992 cubic feet, from which five cases have been removed. It was inhabited by two families, numbering fourteen persons. They belong to the class known in Scotland as "tinklers."

FAITH-HEALING AT DUNOON.

A case of faith-healing, attended by rather tragic results, is reported from Dunoon, on the Firth of Clyde. It seems that a certain poor woman had been ailing for seven years from what is described as a form of paralysis, for which she underwent some kind of operation in the Western Infirmary five years ago. Early in March last she was "converted," and after this her friends suggested that her body might be made sound as well as her soul by means of faith-healing. For this end a meeting at her house was arranged for Friday, March 30th, and in anticipation of this the woman became greatly excited. The meeting actually took place on Monday, April 2nd, when nine of her friends (of the Baptist denomination) visited her, prayed with her, and read passages of Scripture bearing on faith-healing; these passages she repeated, expressing her belief in them. During this process she was crying, holding her head, and shaking "till ye could hear the bones cracking in

her body." She was then lifted into bed, and her head was anointed with oil. As the result of all this the poor woman became gradually more and more excited, and in a few days had to be removed to Lochgilphead Asylum, insane. A committee of the local parochial board is at present investigating the case.

DUBLIN.

(From our own Correspondent.)

ROYAL COLLEGE OF SURGEONS IN IRELAND.

ON the 3rd inst. the President and Council will meet in order to elect from among the Fellows of the College the following Examiners:—Four Examiners in Anatomy and Comparative Anatomy; a similar in Surgery and Surgical Pathology; two in Physiology and Histology; two in Medicine and Therapeutics; two in Midwifery and Gynæcology; two in Physics, Chemistry, and Medical Jurisprudence; and two in Ophthalmic Surgery. Also three Examiners in Midwifery and Gynæcology, to examine candidates for the Diploma in Midwifery; and three Fellows of the College and three Registered Dentists, to examine candidates for Licence in Dentistry. Besides these, three Examiners in General Education will be elected, and four for the Diploma in Public Health. For the latter it is not necessary that the candidates for office should be Fellows of the College. The regulations for the Fellowship Examinations, which have recently been revised, will render the examinations much more stringent than formerly.

THE MEATH HOSPITAL.

On Saturday last in the Lecture Theatre, the Medical and Surgical Prizes for the Winter Session were presented to the successful candidates. The First Medical Prize was obtained by Mr. Thomas Galavan, and the Second by Mr. Thomas M. Bentley; while the Senior Surgical Prize was awarded to Mr. A. Ogilby (1st) and Mr. Wilfred Wynne (2nd); and the Junior Surgical to Mr. Armand McFarland (1st) and Mr. Nathaniel George Cookman (2nd). Prizes also were distributed to several gentlemen who had acted as clinical clerks, and also to resident pupils. A vote of thanks to Sir G. B. Owens, M.D., who presided, terminated the proceedings.

HEALTH OF DUBLIN DURING THE MARCH QUARTER.

Zymotic diseases caused 377 deaths, showing a decrease of 126 as compared with the previous quarter, but 165 in excess for the corresponding quarter of last year. Twenty-six cases of small-pox were admitted to hospital during the quarter, and it is satisfactory to find that only a single death occurred from this disease. The death-rate of Dublin is still exceedingly high, the deaths last quarter affording an annual ratio of 31·4 per 1000 of the estimated population.

CONJOINT SCHEME BETWEEN THE COLLEGES OF PHYSICIANS AND SURGEONS.

At the April examinations for the Second Professional of the Conjoint Scheme exactly 50 per cent. of the candidates were rejected. As an explanation, it may be mentioned that a large number of the candidates had been unsuccessful on a previous occasion.

TESTIMONIAL TO SIR GEORGE OWENS, M.D., J.P.

The subscription list closed yesterday, and the public presentation of the testimonial will take place on Thursday, the 3rd inst., at Sir George Owens' residence, by Lord Ardilaun, the chairman of commiteee, when all contributors to the fund are invited to be present.

Dublin, May 1st.

PARIS.

(From our own Correspondent.)

SACCHARINE.

IT is only a few months ago that saccharine was introduced into France, and there is already a reaction against it. At a recent meeting of the Academy of Medicine, Dr. Worms communicated the result of his researches with this new drug from both a therapeutical and an alimentary point of view. It is known that saccharine communicates to liquids to which it is added a sweet savour similar to that of cane sugar. Its sweetening power, however, is much more considerable, and is 280 times greater than that of ordinary sugar. As this substance so closely resembles sugar in taste, though without possessing its chemical and physiological properties, it was considered a very good substitute for it in diabetic cases. Dr. Worms, in wishing to verify the results indicated by Leydac, performed certain experiments, which showed that in general the animals experimented upon did not suffer by the addition of this substance to their food, although some of them refused it after a few days. Certain insects, such as the common fly, wasps, and bees, absolutely refused to taste those substances to which saccharine was added. Among the applications of saccharine to medicine, one of the most interesting is the prospect of rendering the food and drink of diabetics sweet without any fear of augmenting the glycosuria. It has been ascertained that saccharine is not a sugar, and that it passes through the organism without undergoing any modification. The entire quantity ingested is found in the urine, to which it communicates a sweet taste. Dr. Worms administered saccharine in divers forms, and in doses of ten centigrammes per day, to four persons affected with diabetes in different stages. Only one has been able to support it, who has been continuing it for the last two months; whilst the other three had to give it up, as they suffered from serious troubles in the stomach. In one of the three patients its employment was resumed after a month's suspension, and it caused identical troubles at the end of ten days. From this Dr. Worms concludes that there is certainly a risk in introducing saccharine in the alimentation of diabetics, and if used at all it should be done with the greatest caution, one of the essential conditions of the treatment of these patients being to preserve intact their nutrition. Dr. Dujardin-Beaumetz said that he had not noticed any accidents in patients to whom he had administered saccharine, but believed that the accidents above referred to may occur, and that this substance may interfere with the digestive power of the gastric and pancreatic juices.

PROFESSOR SÉE ON DIGESTION.

In a lecture on the modern notions of digestion and alimentation, Professor Germain Sée treated of the nutritive value of *bouillon*, or broth, and his conclusions may be summed up as follows: 1. The quantity of albuminates is always very feeble, and it is the less so when the meat has been slightly boiled. The broth therefore conveys but very little of the albuminates to the organism, as the greatest portion remains in a coagulated state in the meat. 2. The gelatine contributes but indirectly to the reorganisation of the system; it may, in decomposing itself, produce heat. It serves particularly to protect the corporeal albuminates, which would be more readily consumed in their absence, but they do not regenerate the tissues of the body. 3. A small quantity of carbohydrates is found in broth. The glycogenic matter, the inosite, the sugar, and the lactic acid which are met with in fresh meat, soon undergo profound alterations. It may be supposed, *a priori*, as observed by Brücke, that the glycogen is transformed into sugar, and that the sugar itself undergoes transformation into lactic acid; but M. Sée remarks that the lactic acid of muscle is not identical with that of the fermentation of sugar; the first turns the plane of polarisation to the right; lactic acid has no optical character. 4. Among the organic substances may be still added certain quaternary products, creatine, creatinine, and carmine, but the physiological action of which is little understood. 5. The saline matters play a *rôle* much more considerable; the phosphoric acid which is met with in the broth contributes to the consolidation of the osseous system; the chloride of sodium abounds in the liquids, and it is to the chlorides as well as to the phosphates that has been attributed the nutritive value of *bouillon*, or broth, which, after all, is only a saline solution. Professor Sée concludes that all physicians, all persons healthy or sick, readily recognise in broth a comforting effect, and they certainly would not substitute for it a warm solution of the phosphate of potash and kitchen salt. M. Sée does not pretend to explain in what consists the virtue of broth. It is not, he says, an alimentary means, for if in a convalescent milk be replaced by the strongest beef-tea the result would be disastrous; but if, as frequently happens, milk is not well borne by young children, if it should cause persistent diarrhœa, it may, during a suspension of one or two days, be

replaced at first by concentrated broth, which may afterwards be advantageously mixed with cow's milk. Milk alone is indigestible; broth alone would lead to inanition, as it contains, abstraction being allowed for salts, but very little organic substances, too little of albuminates, too little of carbo-hydrates, and the fat which is found in it is not so easily digested as that of milk.

DEATH OF M. DURAND-CLAYE.

M. Alfred Durand-Claye, chief engineer of the city of Paris, whose function it was to attend to the sanitary condition of the drains, died suddenly on the night of April 29th. He was only forty-seven years of age, and was for several years one of the most zealous members of the Board of Public Works, in which capacity he contributed to a very great extent to the improved sanitary condition of this city. He was one of the most intelligent civil engineers that France has possessed for some time. He displayed pre-eminent qualities as a hygienist; and in all the debates concerning the disposal of the refuse matter of this city his opinion was always received with consideration. He was a great partisan of *tout à l'égout;* that is to say, that all the refuse matter of privies, cesspools, &c., should be emptied into the drains and thence into the Seine, but some distance below, so as not to infect the town. In order to effect this, the water supply of Paris must be infinitely greater than it is at present.

Paris, May 1st.

EGYPT.

(From our own Correspondent.)

PROFESSOR VIRCHOW'S VISIT.

THE great Professor, who is almost unknown to the laity except in connexion with the present Emperor of Germany, has lately been spending some days in Cairo, after his return from the Upper Nile, and previously to his departure for Athens and Mycenæ. He showed great interest in visiting the various hospitals here, and especially Kasr el Aini and the adjacent medical school. He fully recognises all the reform that has been introduced into the native hospitals, which he found airy and free from all danger of hospital taint, but he tried to impress upon the Egyptian professors in the medical school the importance of bringing themselves up to the level of their European brethren. He gave an address in German, translated phrase by phrase into Arabic, to the new Medical Society which has just been formed under the presidency of Dr. Salem Pacha. He spoke of the past knowledge of the ancient Egyptians, and impressed upon his hearers the importance of hygiene and of introducing true sanitation as met with in England and Germany. His address was listened to most attentively by eighty native doctors. On another evening an Arab dinner was given in his honour by Salem Pacha, to which fifteen European and an equal number of native doctors were invited. Eight nationalities were represented, and it was noted that every medical man talked two languages fluently, while most of them talked more than four. The palm must, however, be given to Dr. Schliemann, who was one of the guests, and who is said to talk every European language except Finnish.

THE CAIRO SEASON.

The tourists and winter residents are now leaving for Europe in large numbers, though the climate is still pleasantly cool. There has been a greater influx of American and English visitors than in any previous year, in spite of the mild dengue epidemic which frightened people from coming here until December. The proprietors of two of the hotels have announced their intention of building additional wings before next winter.

STREET SANITATION.

Of late years there have been great complaints of odours arising from certain principal streets in Cairo, and energetic steps are now being taken to remove this nuisance. It was found that gas-pipes of insufficient size and made of a zinc composition allowed free leakage into and discolouration of the surrounding soil, which smells of sulphuretted hydrogen when exposed to the air. These gas-pipes are now being replaced by six-inch iron pipes in all the important streets. Although there is no system of drainage in the town, five most unnecessary sewers have been constructed in times past to carry off rain and surface water. It is known that rain only falls in Cairo in showers during a dozen days in the year, so that the sewers might remain empty if it were not for the reckless use which has been made of them by proprietors of adjacent houses. To save trouble and the expense of constructing well-cemented cesspools, owners connect their house drains with the street sewer, and manage to escape punishment by sheltering themselves behind the capitulations for foreigners. As the sewers were of four-feet diameter, unprovided with a proper fall, and intended to empty themselves into the Nile or tributary canals, it was decided early this year to block them throughout. About half the work has been accomplished, but there remain two sewers as yet untouched.

Cairo, April 18th.

THE SERVICES.

ARMY MEDICAL STAFF.—Surgeon-General John Irvine, M.D., Honorary Physician to the Queen, has been granted retired pay (dated April 13th, 1888); Deputy Surgeon-General John Tulloch, M.D., is granted retired pay (dated May 2nd, 1888); Brigade Surgeon William James Wilson, M.D., is granted retired pay (dated May 2nd, 1888); Brigade Surgeon Thomas Rudd, M.D., to be Deputy Surgeon-General, ranking as Colonel, vice R. W. Clifton, retired (dated April 11th, 1888); Surgeon-Major George William McNalty, M.D., F.R.C.S.I., to be Brigade Surgeon, ranking as Lieutenant-Colonel, vice T. Rudd, promoted (dated April 11th, 1888); Surgeon-Major Samuel Gamble White, M.D., retires on retired pay, and having applied to retire prior to January, 1888, is granted the honorary rank of Brigade Surgeon (dated May 2nd, 1888).

ARMY MEDICAL RESERVE OF OFFICERS.—The undermentioned Surgeons-Major to be Surgeons-Major, ranking as Lieutenant-Colonels (dated May 2nd, 1888): Francis Bonney, 3rd Battalion, the East Surrey Regiment; Edward Albert Rawson, 8th Battalion, the King's Royal Rifle Corps; and Charles Baker Stoney, M.B., 3rd Battalion, the Prince of Wales's Leinster Regiment (Royal Canadians).—The undermentioned Surgeons to be Surgeons-Major, ranking as Majors (dated May 2nd, 1888): Andrew Clark, 4th Middlesex Rifle Volunteer Corps, and William Hall, F.R.C.S.E., 5th Lancashire Artillery Volunteer Corps.—The undermentioned Officers to be Surgeons, ranking as Captains (dated May 2nd, 1888): Surgeon William Henry Brownbill Crockwell, the Manchester Division, Volunteer Medical Staff Corps; Surgeon Thomas William Richardson, 1st Volunteer Battalion, the Norfolk Regiment; Acting Surgeon Robert Burnet Porteous, M.D., 2nd Lancashire Rifle Volunteer Corps; Acting Surgeon Robt. Thos. Alexander O'Callaghan, 1st Flintshire Engineer Volunteer Corps; Acting Surgeon Francis John Walker, M.B., 1st Volunteer Battalion, the Lincolnshire Regiment; Surgeon Alexander Dall MacDonald, M.D., 3rd Volunteer Battalion, the King's Own Scottish Borderers; Acting Surgeon James Turton, 1st Volunteer Battalion, the Royal Sussex Regiment; and Acting Surgeon John Alexander Mackenzie, M.B., 4th Lancashire Rifle Volunteer Corps.

INDIA OFFICE.—The Queen has approved of the retirement from the Service of the undermentioned Officers: Brigade-Surgeon Emanuel Bonavia, M.D., Bengal Medical Establishment (dated April 26th, 1888); Surgeon-Major Hamilton De Tatham, M.D., Bombay Medical Establishment (dated April 1st, 1888).—The date of retirement of Surgeon-General William James Moore, C.I.E., Bombay Medical Establishment is altered to Feb. 26th, 1888.

ADMIRALTY.—The following appointment has been made: John Connell to be Surgeon and Agent at Crosshaven.

CENTENARIANS.—Mrs. Agnes Smith, a Glasgow lady, now living in Melbourne, has reached the age of 105 years. She is said to have made the first cup of tea drunk in the colony.—Ann Higgs died this week in the Leicester Workhouse at the age of 101 years. For many years she was a schoolmistress. She retained the use of all her faculties up to the last.

MEDICAL MAGISTRATE.—Mr. Oliver Penfold, M.R.C.S., of Sandhurst, Victoria, has been appointed to the Commission of the Peace for the Midland Bailiwick of the Colony of Victoria.

Medical News.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.—The following is a list of Members elected to the Fellowship at the meeting of the Comitia on the 26th ult.:—

Beevor, Charles Edward, M.D.Lond., Harley-street.
Caton, Richard, M.D.Edin., Liverpool.
Cole, Thomas, M.D.Lond., Bath.
Drewitt, Fredk., G. Dawtrey, M.D.Oxon., Brook-street.
Hadden, Walter Baugh, M.D.Lond., Welbeck-street.
Longstaff, George Blundell, M.B.Oxon., Wandsworth.
McConnell, James Fredk. Parry, M.D.Aberd., Finborough-rd.
Tooth, Howard Henry, M.B.Camb., Harley-street.
White, William Hale, M.D.Lond., Harley-street.

The following candidates, having conformed to the bye-laws and regulations and passed the required examinations, were admitted Licentiates of the College:—

Ainsworth, H. P., Guy's.
Allen, Vernon, St. George's.
Anwyl, J. Norman, St. Barthol.
*Applegate, J. Wm., St. Barthol.
*Appleton, J. Ellis, St. Mary's.
Ashford, Claude H., St. Barthol.
Austen, T., Charing-cross.
Aveline, H. Talbot Sidney, Bristol.
Aymard, J. Law, Guy's.
*Ballingall, G. Anderson, Edinb. Univ. and St. George's.
*Barford, A. Morton, St. Barthol.
*Barnett, Horatio, Camb. Univ. and St. Thomas's.
*Baron, Horatio Nelson, King's College.
Barr, J. Coleman, St. Mary's.
*Beckett, Louis, London.
*Belding, Davey Turner, St. Barthol.
*Bell, B. Stock, St. Thomas's.
*Bird, Robert, St. Barthol.
*Blunt, A. H., St. Thomas's.
*Bontor, Sidney Algernon, St. Barthol.
Bour, Ed. François, Univ. Coll.
*Boyce, R. Wm., Univ. Coll.
*Braide, George, Manchester.
Braye, Reginald James, London.
Bristowe, Hubert Carpenter, St. Thomas's.
Brock, Ernest Henry, Guy's.
*Brooks, F. Augustus, St. Mary's.
*Brown, J. Daniel, St. George's.
Cappe, Herbert Nelson, Univ. Coll.
Chambers, A. E., Manchester.
Chand, Fateh, Newcastle-on-Tyne.
*Charsley, R. S., Westminster.
*Clayton, C. Hollingsworth, Univ. Coll.
Clifford, Thomas, Newcastle-on-Tyne.
*Colby, J. G. Ernest, St. Barthol.
Collier, Charles, London.
Collins, Frank, Univ. Coll.
Cooper, Edward, Charing-cross.
Corner, Frank, London.
*Couch, J. Kynaston, Middlesex.
*Coulton, J. James, London.
Cox, Alfred E., St. Thomas's.
Crane, Horace C. Fdk., London.
*Cruickshank, J. David, Guy's.
Daniell, G. Warwick Bampfylde, St. George's.
Daniell, Benjn. Adams, Dublin.
*Dowdell, C. Seymour, Univ. Coll.
*Edwards, C. Wright, Middlesex.
*Fenwick, W. Soltau, London.
Fremlin, Heaver Stewart, Westminster.
*Flux, G. Belben, King's Coll.
Gilmour, Percy Graham, St. Barthol.
Goldsmith, Perry David, Vict. Univ., Ontario.
Goulston, A., St. Thomas's.
*Grange, Frank, Charing-cross.
Head, Timothy John, London.
Hearnden, E. Morgan, Guy's.
Heasman, Frank, St. Barthol.
Hebblethwaite, Sept. Montague, St. Barthol.
Heberden, G. Alf., St. George's.
*Helsham, Wm. Macdonald, St. Thomas's.
*Hicks, Philip, St. Barthol.
*Hill, Hedley, Bristol.
Hogg, F. Stapleton Dickey, St. George's.
*Holford, Walter Stanley, St. George's.
Holman, Frank Kay, Guy's.
Hudson, C. Tilson, Bristol.
Hunt, Arthur Henry Wm., Westminster.
*Hutton, J. Alfred, Middlesex.
*Jones, Arthur W. Llewelyn, St. Barthol.
*Jones, Richard, London.
Kenwood, H. Richard, London.
Ker, J. Errington, St. Thomas's.
*Lane, W. Byam, St. Barthol.
Lockyer, Conrad William, St. Thomas's.
*McLaren, Kenneth, St. Barthol.
Maillard, W. Job, Guy's.
Mathias, W. Lloyd, St. Thomas's.
Metcalfe, G. Herbert, Guy's.
Moberly, Sydney C. Hillyard, St. Barthol.
Molson, J. Cavendish, London.
Moores, S. Guise, St. Thomas's.
Morris, E. Walter, St. Thomas's.
*Moss, Enoch, Guy's.
*Moyse, J. Edwin, Guy's.
Nelson, W. Bremner, Middlesex.
*O'Kinealy, Fredk., St. Barthol.
*Oxley, Fredk. John, London.
Owen, J. Vaughan, King's Coll.
*Parkinson, J. Porter, Univ. Coll.
Parsons, Fredk. G., Middlesex.
Pegge, E. Vernon, King's Coll.
Penno, Francis Forbes Lanyon, Univ. Coll.
Phillips, Edgar Vaughan, St. Thomas's.
Poolman, Arthur E., Guy's.
Pridham, W. Frederic, St. Mary's.
*Purvis, Alfred, Charing-cross.
*Ransom, W. Bramwell, Univ. Coll.
Richards, Thomas, Bristol.
*Ridley, Nicholas C., St. Mary's.
*Robbins, Tom Wiltshire, London.
Roberts, John Lloyd, Guy's.
*Robinson, Norman Battye, St. George's.
Sandoe, John Warden, Guy's.
Seagrave, G. H., Univ. Coll.
*Seal, C. E., Univ. Coll.
*Seddon, H. Bonvil, St. Thomas's.
*Sharpe, W. Salisbury, St. Mary's.
Sims, G. Samuel, St. Thomas's.
*Stanley, C. J., King's Coll.
Steele, E. A. Taylor, Liverpool.
Stevens, C. H., Univ. Coll.
Swayne, Walter Carless, Guy's.
*Vines, C. Stuart, Westminster.
*Wade, Herbert, Manchester.
*Walker, Reginald Field, St. Thomas's.
Walls, W. Kay, Manchester.
*Ward, Ernest, Bristol.
Watson, John, Westminster and Newcastle-on-Tyne.
Whitehead, H. E., St. Barthol.
*Williams, Herbert, St. Barthol.
*Williams, J. Price, Manchester.
Wynter, A. Ellis, St. Barthol.
Yates, Wm. Bartlemore, Manchester.

* Approved by Examining Board.

UNIVERSITY OF OXFORD.—At a congregation held on April 27th the following degree was conferred:—

Doctor of Medicine.—Francis H. Champneys, Brasenose.

UNIVERSITY OF CAMBRIDGE.—At a congregation held on April 27th, the report of the Council of the Senate, recommending that a provision be inserted in the proposed statute on the *status pupillaris* declaring that Bachelors of Medicine who are of less than five years' standing from the date of matriculation shall be deemed to be *in statu pupillari*, was rejected by a majority of 22 against 21. The following degrees were conferred:—

Bachelors of Medicine.—Chichester Gould May, Trinity; Ebenezer Hunt Cooke, St. John's; Thomas Brushfield, Gonville and Caius.
Bachelor of Surgery.—Ebenezer Hunt Cooke, St. John's.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS OF EDINBURGH, AND FACULTY OF PHYSICIANS AND SURGEONS OF GLASGOW.—At the April sittings of the examiners for the triple qualification held in Glasgow, the following candidates passed the respective examinations, and were admitted L.R.C.P.Ed., L.R.C.S.Ed., and L.F.P.S.Glasg.:—

Christopher Carruthers, Edw. Brooks, Arthur Nicholson, A. F. Crinan, Dugald Buchanan, James Brown, J. Freeland Fergus, M.A., G. A. Bannatyne, Robert W. Roberts, John T. Haworth, John Steele, and James Kelly, of the Glasgow Medical School; Cabanis F. de Mello, of the Bombay and Glasgow Schools; Ernest Carter, of the London School; V. C. Vanderstraaten, of Ceylon Medical College.

UNIVERSITY OF GLASGOW.—The customary graduation ceremony at the close of the winter session took place on April 27th, when the following degrees were conferred:—

Doctors of Medicine.—James Jenkins Campbell, M.B., C.M., Scotland; John R. Gibson, M.B., C.M., Scotland; Robert Denham Pinnock, M.B., C.M., Australia.

SOCIETY OF APOTHECARIES.—The following candidates, having passed the qualifying examination in Medicine, Surgery, and Midwifery, have received certificates entitling them to practise in the same, and have been admitted as Licentiates of the Society:—

Andrew, Bennett Harvey, Tyrwhitt-road, St. John's.
Cooke, Montague Percy, Fern House, Landkey, Barnstaple.
Eyton-Jones, John A., Wrexham, North Wales.
Goldsmith, Perry David, Campbellford, Ontario.
Macdonald, Isabella Macdonald, Windmill House, Arbroath.
Merrall, Harry, Victoria-terrace, Bury, Lanc.
Nall, Joseph, Whaley Bridge, near Stockport.
Reichardt, Ernest Noel, St. Bartholomew's Hospital.
Valentine, T. Harcourt Ambrose, Green-lane, Addlestone.

The following passed the Surgical part of the examination:

Evans, Ernest W., St. Bartholomew's Hospital.
Johnson, Benjamin Pitt, Liverpool School of Medicine.
De la Motte, William, London Hospital.
Part, John Shepley, Westminster Hospital.
Potter, Paul de Cressé, Owens College, Manchester.
Smith, John Arthur, Leeds School of Medicine.
Stephenson, Owen Taunton, Liverpool School of Medicine.

The following passed the Medical part of the examination:

Brown, Francis Joseph, Middlesex Hospital.
Cochrane, James Mackeand, Toronto.
De Butts, Arthur John, St. Mary's Hospital.
Seccombe, Samuel Herbert, Guy's Hospital.

At the Primary Examination the following passed:—

Whole Examination.—John Cecil Mackmurdo Given, Liverpool School of Medicine.
Anatomy and Physiology.—Cecil Peter Margetson Swales, St. Bartholomew's Hospital.
Anatomy only.—Nevil Potton Cadel, Guy's Hospital; John Marchant Fry, Westminster Hospital.
Chemistry, Botany, and Materia Medica.—Sidney Ernest Atkins, St. Bartholomew's Hospital; Herbert Massingham, London Hospital; James Thomas Roger Miller, St. Thomas's Hospital; William Leveson Gower Morgan, St. Thomas's Hospital; Henry Bartlett Shillingford, Guy's Hospital.

UNIVERSITY OF LONDON.—At a recent meeting of the Senate the following gentlemen were elected Examiners for 1888-89:—Chemistry: Professor J. Emerson Reynolds, M.D., F.R.S., and Professor W. A. Tilden, D.Sc., F.R.S. Botany and Vegetable Physiology: Professor F. Orpen Bower, D.Sc., M.A.; Professor H. M. Ward, M.A. Comparative Anatomy and Zoology: Professor E. Ray Lankester, M.A., F.R.S.; Adam Sedgwick, M.A., F.R.S. Practice of Medicine: William Cayley, M.D.; Professor F. T. Roberts, M.D., B.Sc. Surgery: W. Morrant Baker; Professor Christopher Heath. Anatomy: Professor John Curnow, M.D.; Professor Alex. Macalister, M.D., M.A., F.R.S. Physiology: J. N. Langley, M.A., F.R.S.; Professor E. A. Schäfer, F.R.S. Obstetric Medicine: F. H. Champneys, M.A., M.B.; Professor John Williams, M.D. Materia Medica and Pharmaceutical Chemistry: J. Mitchell Bruce, M.D., M.A.; Frederick Taylor, M.D. Forensic Medicine: Professor G. V. Poore, M.D., B.S.; Thomas Stevenson, M.D.

EXAMINING BOARD IN ENGLAND.—In the list of gentlemen who passed on April 13th, "P. C. Nicholls, of Charing-cross Hospital," should have been H. C. Nicholls.

A NEW Ear and Eye Hospital was opened at Manchester on the 1st inst.

THE ROYAL SOCIETY.—Amongst the fifteen candidates selected by the Council of the Royal Society for election into that body we observe the names of Mr. T. P. Teale of Leeds, and Mr. H. Trimen, M.B.

THE Tower Gardens, on land between the disused moat of the Tower and Trinity-square, were opened for public recreation on the 30th ult. The cost of the ground and expenses during the first year are estimated at £1020.

THE GREAT TRIENNIAL HANDEL FESTIVAL, 1888.—Many members of the medical profession will be interested to learn that this festival will take place in the Crystal Palace on June 25th, 27th, and 29th.

ST. MARY'S HOSPITAL MEDICAL SCHOOL.—Mr. John F. H Broadbent, of Hertford College, Oxford, has been awarded a scholarship of £50 in Classics; Mr. Pryce, of Pembroke College, Cambridge, a scholarship of £50 in Mathematics.

A BOON.—The introduction of small stalls with refreshments at prices within the means of the poor in the out-patient department of our hospitals in view of the patient being unavoidably kept waiting, often for some time, has lately been provided at several of our London hospitals.

THE EMPEROR OF GERMANY.—It will interest the innumerable admirers of and sympathisers with the illustrious German invalid to learn that his comfort has been considerably enhanced by a cleverly constructed apparatus for holding books over a bed, known as the literary machine, which the Kaiserin had herself ordered from the inventor, John Carter, of New Cavendish-street, London, and with which his Majesty was much pleased.

LITERARY INTELLIGENCE.—The early publication of "Physiological and Pathological Researches," by the late T. R. Lewis, M.B., F.R.S., is announced by Mr. H. K. Lewis, of Gower-street. The editors are Sir William Aitken, M.D., F.R.S., G. E. Dobson, M.B., F.R.S., and A. E. Brown, B Sc., and the work will be well illustrated. We understand that only a very limited number of copies will be for sale, and it will not be reprinted.

CHILDREN'S HOSPITAL, NOTTINGHAM.—A satisfactory report was presented to the governors and friends of this institution at the annual meeting held at the Exchange Hall last week. The Mayor (Mr. Alderman Turney) presided. The balance sheet showed the receipts from all sources (including legacies amounting to £820, and cot fund £214 19*s.* 11*d.*) to reach a total of £2062 15*s.* 4*d*, and the disbursements to be £1893 1*s.* 8*d.* Colonel and Mrs. Seely had generously offered to lend their house, Sherwood Lodge, during the summer and autumn months as a convalescent home in connexion with the hospital, and to bear all the expenses.

BEQUESTS.—Mr. Daniel Wood, of Moorfield, Glossop, Derbyshire, having previously given £6000 to the corporation of Glossop to establish a hospital for the sick poor to be called the "Wood Hospital," bequeathed £19,000 for endowment of the hospital.—Mr. James Patry, late of 7, Cambridge-terrace, Regent's-park, bequeathed £100 each to University College Hospital, the Metropolitan Free Hospital (Gray's-inn-road), and the Hospital for Incurables (Great Ormond-street).—A legacy of £100, free of duty, has fallen to Hawick Cottage Hospital by the will of the late Miss Dickson of Hassendeanburn, who died in Edinburgh a few days ago.

THE LONDON (CITY) WATER SUPPLY.—We are glad to observe that the important question of a constant supply of water to the City was brought before a meeting of the Court of Common Council last week. Memorials from the parishes of St. Augustine and St. John respectively were laid before the Court, praying that notices, as required by the Metropolis Water Act, 1871, may be given to the water companies supplying the City to provide a constant supply. A good deal of discussion ensued. The existing conditions of the supply, and the excessive rates charged to the consumer for it, were warmly animadverted upon, but a motion was eventually carried that the memorials be referred to the Gas and Water Committee.

PRESENTATIONS. — At a meeting of the Court "Lord Clyde," 3887, Ancient Order of Foresters, held on Tuesday last, Dr. Richardson was presented with a testimonial in recognition of fourteen years' service as the lodge doctor, which consisted of a handsome marble clock, appropriately inscribed, together with a beautifully framed illuminated address.—Dr. Hime, medical officer of health for the borough of Bradford, has just been presented with a highly complimentary address on the expiration of the five years of his office, by the medical practitioners of that town, whose signatures, eighty-six in number, it bears, and which expresses the hope that he may long be spared in health and vigour to prosecute among them his duties as medical officer of health for the borough. It is elaborately illuminated on five pages in book form, bound in red morocco, with gold ornaments and inscription.

KING'S COLLEGE HOSPITAL.—On Monday last the Right Hon. Lord Justice Bowen took the chair at a dinner held at the Hôtel Métropole, to urge the claims of the above institution upon the liberality of the public. He was supported by a large gathering of well-wishers of the hospital. After the usual loyal and patriotic toasts, the chairman, in eloquent terms, proposed "Success to King's College Hospital." He dwelt upon the widespread character of its work, and spoke of the financial difficulties of some few years ago, which had been met and overcome by the generous aid of the medical and surgical staff and other friends of the institution. The Rev. Dr. Wace, chairman of the Committee of Management, said the three points to which the committee mainly looked for success were efficiency, economy, and publicity. At the close of the meeting subscriptions amounting to over £2200 were announced. Among the speakers were Mr. Justice Cunningham, Major-General Sir Richard Pollock, K.C.B., Admiral Sir G. Richards, K.C.B., Sir Alfred Lyall, Mr. Richard Twining, the treasurer of the hospital, Professor Lionel Beale, F.R.S., the senior physician, and Professor John Wood, F.R.S., the senior surgeon.

MEDICAL NOTES IN PARLIAMENT.

The Contagious Diseases Acts in India.

IN the House of Lords on the 1st inst., in reply to the Bishop of Carlisle, Viscount Cross said that he had noticed that a very sensational paper on the Contagious Diseases Acts in India had been extensively published, containing facts which he could not believe were true. He had communicated with the Viceroy, who has made a thorough investigation into the subject. This information, however, could not be laid before the House, because it had not yet come to him in an official form. If any such practice were found to exist as detailed in the paper, it should be stopped.

In the House of Commons, on the 27th ult., Sir J. Fergusson, in the absence of Sir J. Gorst, stated that the Secretary of State has been informed that the question of the Contagious Diseases Acts is being inquired into separately in the Home Department of the Government of India. A report was expected, but had not yet arrived. If it should not arrive by the next mail the Secretary of State would cause a telegraphic communication to be made to the Government of India.

Lime Juice on Merchant Ships.

In the House of Commons, on the 27th ult., in reply to Mr. Knatchbull-Hugessen, Sir M. Hicks-Beach said that he had no reason to suppose that the provisions for the issue of lime juice on board merchant ships, as directed by Section 4 of the Merchant Shipping Act of 1887, were frequently neglected. Whenever a case of such neglect was reported to the Board of Trade proceedings were at once taken, either to inquire into the master's conduct in the matter, or to sue for the penalties recoverable if the circumstances justified it, and if proceedings were possible.

The Sweating System in Manchester.

In reply to Sir H. Roscoe, Mr. Stuart Wortley stated that the Factory and Workshop Act, 1878, did not transfer any jurisdiction from the local authorities to the factory inspectors in respect to any workshops. It transferred from the factory inspectors to the local authorities the supervision of sanitary provisions in all workshops in which men only work, and in which women work with men or by themselves. A special report had not been made as to the condition of the sweaters in Manchester, but several prosecutions had taken place for the overwork of women and young persons in that city.

Epidemic in Barracks.

On the 30th ult., in reply to Dr. Tanner, Mr. E. Stanhope said that probably on account of the changeable weather lung disease had been rather prevalent in the west of Ireland, and in the weekly return to the 20th ult., from the Bedfordshire Regiment at Fermoy, it was shown that there had been thirteen admissions for pneumonia and one death. The sanitary state of the barracks was reported to be satisfactory, and no cause other than the weather had been assigned for the outbreak. Further inquiry has, however, been ordered.

Medical Officers and Medals.

Sir Henry Fletcher asked the Under-Secretary for India whether the medical officers and establishments who served on board the hospital ship *Tenasserim* in the late Burmese war, and who had sole charge of the invalids, sick, and wounded, which invalids were brought down the river to Rangoon from Mandalay and placed on board the ship simply because she drew too much water to go up the river, were entitled to the medal

and gratuity as if the ship had gone up the river, which was the only reason assigned for not treating them as medical officers in a similar position had always been treated.—Sir John Gorst replied that the medical officers in question were not entitled to the medal or clasp, the issue of which was limited to those who were either in Upper Burmah or in actual conflict with the enemy. The case of the gratuity was different. It was not known whether the medical officers on board the *Tenasserim* received it, but it was granted to the crews of H.M.'s ships of war in the Rangoon war.

Return of Lunatic Asylums.

On the 1st inst., in reply to Mr. W. Corbet, Mr. Matthews stated that this return was almost completed, and would, he hoped, be in the hands of members in a few days. The return was a heavy one, and the delay had been unavoidable.

The Vaccination of Infants.

In answer to Mr. W. M'Laren, Mr. Ritchie stated that if children born in a workhouse were not vaccinated before their discharge they commonly escape vaccination altogether, and the Local Government Board are advised that there is no medical reason against early vaccination in the case of healthy children.

Small-pox at Sheffield.

In answer to Mr. Picton, Mr. Ritchie stated that an exhaustive inquiry into the circumstances of the epidemic of small-pox at Sheffield by one of the Board's medical inspectors is still in progress. The object of the inquiry has been to ascertain the conditions under which the epidemic arose and spread, and especially how far vaccination and want of vaccination have been concerned with the prevalence of the disease. A provisional report has been submitted, and the analysis of the voluminous returns prepared locally is now being proceeded with. As soon as this is completed, the final report will be at once prepared, and laid on the table of the House.

Army Medical Officers.

In answer to Dr. Tanner, Mr. E. Stanhope said that retired medical officers would be employed from time to time as their services become necessary. When so re-employed their remuneration is limited by the Royal Warrant to a sum of £150 a year beyond their retired pay, and their service does not count towards increase of retired pay. This re-employment during peace is entirely at the option of the retired officers, and in time of national emergency the conditions of employment would be altogether different.

Victoria University Bill.

On the 2nd inst. this Bill was read a second time.

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column are invited to forward it to THE LANCET Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week for publication in the next number.

ARCHER, A. M., B.A.Dub., M.D., M.B., B.Ch., has been appointed Visiting Surgeon to the District of Bishopfield, Chester.

BAILEY, T. RIDLEY, M.D.Ed., has been reappointed Medical Officer of Health for the Bilston Urban Sanitary District.

DE RENZI, ARTHUR C., M.R.C.S., L.S.A., late Surgeon of the N. Z. Shipping Co.'s R.M.S. *Rimutaka*, has been appointed House Surgeon to the Christchurch Hospital, New Zealand, vice C. Bancroft, resigned.

FOX, E. L., M.A., M.B.Camb., M.R.C.S., has been appointed Senior House Surgeon to the Stanley Hospital, Liverpool.

GIDDINGS, GEORGE T., M.B., M.R.C.S., has been appointed House Surgeon to the London Hospital, vice G. B. Hasdip, M.R.C.S., L.R.C.P., resigned.

HARRISON, JAMES, M.B., C.M.Ed., has been appointed Surgeon to the Allendale and Whitfield Benefit Society.

HERBERTSON, J. C., M.A.Glas., M.D., M.B., C.M., has been appointed Surgeon to the Combination Hospital for Johnstone, Kilbarchan, Erskine, and Inchinnan.

HOLYOAKE, J. P., L.R.C.P.Ed., M.R.C.S., has been appointed Medical Officer for the Kinver District of the Glesdon Union.

KING, H. W., M.D.Ed., M.B., C.M., M.R.C.S., has been appointed Visiting Surgeon to the Saltney District, Chester.

LEWIS, B. ADAMS, L.R.C.P.Lond., has been appointed Medical Officer and Public Vaccinator for the Mydrion District of the Carmarthen Union.

MCLEAN, ALLAN, M.B. and C.M.Edin., L.R.C.S.Ed., L.M., has been appointed Medical Officer of Health for the Portland Urban Sanitary District.

MALCOMSON, J. A., M.D.Q.U.I., L.M., has been reappointed Medical Officer of Health for the Eaton Urban Sanitary District, Yorkshire.

MORTON, THOMAS, M.D.Dur., has been appointed Medical Officer for the Workhouse, Durham.

SAVERY, FRANK, M.R.C.S., L.R.C.P.Lond., has been appointed Senior Assistant House Surgeon to the Hull Royal Infirmary, vice W. F. Pedler, M.R.C.S., L.R.C.P.Lond., L.S.A., resigned.

SMALE, H. C., L.D.S.R.C.S.Eng., has been appointed House Dental Surgeon to the Victoria Dental Hospital, Manchester, vice C. H. Buckley, resigned.

SMITH, G. W., M.R.C.S., L.S.A., has been reappointed Medical Officer for the Gothan District of the Basford Union.

THOMPSON, T. W., L.R.C.P.Ed. and L.M., M.R.C.S., L.S.A., has been appointed Medical Officer of Health for the Harrow Urban Sanitary District, vice Saunders, resigned.

TURNER, F. H., M.R.C.S., L.S.A., has been appointed Public Vaccinator to the Second District of the Wycombe Union.

WINSHIP, WILLIAM A., M.R.C.S., L.S.A., has been appointed Medical Officer for the Aleventon District of the Rothbury Union.

Vacancies.

In compliance with the desire of numerous subscribers, it has been decided to resume the publication under this head of brief particulars of the various Vacancies which are announced in our advertising columns. For further information regarding each vacancy reference should be made to the advertisement.

BLOOMSBURY DISPENSARY, 22, Bloomsbury street.—Physician. An honorarium of 100 guineas is usually voted annually to the Physician.

BURY DISPENSARY HOSPITAL.—Junior House Surgeon. Salary £60, with board (except beer), furnished apartments, and washing.

DORSET COUNTY HOSPITAL, Dorchester.—House Surgeon, to reside and board in the hospital. Salary £70.

HERTFORD BRITISH HOSPITAL, Paris.—House Surgeon.

HOSPITAL FOR DISEASES OF THE THROAT, Golden-square.—Resident Medical Officer. Salary £50, increasing after the first year, with board and lodging.

HOSPITAL FOR EPILEPSY AND PARALYSIS, 32, Portland-terrace, Regent's-park.—Assistant Physician and Registrar.

HOSPITAL FOR WOMEN, Soho-square.—Two Clinical Assistants in the out-patient department. Fee for course of three months, £5 5s.

NORTH STAFFORDSHIRE INFIRMARY.—House Physician. Salary £100 per annum, increasing £10 per annum at the discretion of the Committee, with furnished apartments, board, and washing.

NORTH-WEST LONDON HOSPITAL, Kentish-town-road.—Senior Resident Medical Officer. In the event of the Assistant Medical Officer being promoted to the senior post, candidates should state if they will take the junior appointment.

ROYAL FREE HOSPITAL, Gray's-inn road.—Additional Assistant Physician and additional Assistant Surgeon. Both required to give instruction to students of the London School of Medicine for Women.

SANITARY DISTRICTS OF BARNET, BERKHAMPSTEAD, HEMEL HEMPSTEAD, WATFORD, AND WELWYN UNIONS; AND FOR THE BARNET, EAST BARNET VALLEY, AND TRING LOCAL BOARDS.—Medical Officer of Health. Salary at the rate of £413 per annum (to cover and include travelling and all other expenses), payable quarterly. No fees, travelling expenses, or any other remuneration will be allowed or recoverable.

Births, Marriages, and Deaths.

BIRTHS.

DOUGLAS.—On the 25th ult., at Winthank House, Cupar, Fife, N.B., the wife of Chas. Ed. Douglas, M.D., of a daughter.

LEWTAS.—On the 30th ult., at Henrietta-street, Cavendish-square, the wife of J. Lewtas, M.D.Lond., I.M.S., of a daughter.

LYSTER.—On the 27th ult., at Coleshill, Warwickshire, the wife of Arthur E. Lyster, M.R.C.S., of a son.

NICHOLLS.—On the 27th ult., at The Moat, Eastbourne, the wife of Howard H. J. Nicholls, M.R.C.S., of a daughter.

MARRIAGES

ELLIOT—ARTHUR.—On the 24th ult., at St. Mary's, Charleton, South Devon, by the Rev. W. H. Stone, M.A., Rector of the Parish, Edmund Arthur Savage Elliot, M.R.C.S., L.R.C.P., youngest son of the late John Elliot, F.R.C.S.Eng., of Tresillian, Kingsbridge, to Edith Fanny, only daughter of the late Edward Arthur, Esq., of Slade.

HAMILTON—BODINGTON.—On the 10th ult., at St. James's Church, Vancouver, British Columbia, by the Rev. H. Edwardes, Lauchlan Alexander Hamilton, D.L.S., of Winnipeg, Manitoba, Land Commissioner of the Canadian Pacific Railway, to Constance Eaton, daughter of George Fowler Bodington, M.D., M.R.C.P.Lond., F.R.C.S.Eng., of the City of Vancouver, B.C.

WINGRAVE—MEREDITH.—On the 19th ult. (Primrose Day), at the Church of St. Stephen, Coleman-street, City, by the Rev. H. J. Palmer, M.A., Thomas Wingrave, M.R.C.S.Eng., L.S.A.Lond., of 7, West-street, Finsbury-circus, E.C., and Hazelwood, Ridge-road, Stroud-green, N., to Nellie Meredith, of Battlefield House, St. Alban's, youngest daughter of the late Joseph Meredith, of Bryanston-square, London, W.

DEATHS.

BRODIE.—On the 25th ult., at Colorado Springs, U.S.A., Arthur James Brodie, L.R.C.P.Ed., L.R.C.S.Ed., eldest son of the late Kenneth Sutherland Brodie, Esq., of Bagonbarry, Bengal, and Rutland-square, Edinburgh.

SEQUEIRA.—On the 27th ult., at Waltham Lodge, Tulse-hill, Henry Little Sequeira, M.R.C.S., L.S.A., of Jewry-street, Aldgate, E.C. (of acute bronchitis), aged 63.

SLAUGHTER.—On the 30th ult., at Farningham, Kent, Thomas George Slaughter, M.D., in his 82nd year.

TURNBULL.—On the 23rd ult., at his brother's house, Brighton, James Weatherly Turnbull, Surgeon, of High-street, Dunbar, N.B.

N.B.—A fee of 5s. is charged for the Insertion of Notices of Births, Marriages, and Deaths.

Medical Diary for the ensuing Week.

Monday, May 7.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10.30 A.M., and each day at the same hour.
ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1.30 P.M. and each day at the same hour.
CHELSEA HOSPITAL FOR WOMEN.—Operations, 2.30 P.M.; Thursday, 2.30.
ST. MARK'S HOSPITAL.—Operations, 2 P.M.; Tuesday, 2.30 P.M.
HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M., and on Thursday at the same hour.
METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.
ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
CENTRAL LONDON OPHTHALMIC HOSPITALS.—Operations, 2 P.M., and each day in the week at the same hour.
ROYAL INSTITUTION.—5 P.M. General Monthly Meeting.
ODONTOLOGICAL SOCIETY OF GREAT BRITAIN.—8 P.M. Dr. Edward Blake: On Dental Reflexes and Trophic Changes.—Mr. George Cunningham: On a Statistical Inquiry as to the Results of the Immediate Treatment of Pulpless and Abscessed Teeth.
SOCIETY OF ARTS.—8 P.M. Mr. G. Aitchison: Decoration. (Cantor Lecture.)
MEDICAL SOCIETY OF LONDON.—8.30 P.M. Sir Joseph Fayrer, K.C.S.I.: On the Natural History and Epidemiology of Cholera. (Annual Oration.) To be followed by a Conversazione.

Tuesday, May 8.

GUY'S HOSPITAL.—Operations, 1.30 P.M. and on Friday at the same hour. Ophthalmic Operations on Monday at 1.30 and Thursday at 2 P.M.
ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 4 P.M.; Friday, 2 P.M.
CANCER HOSPITAL, BROMPTON.—Operations, 2.30 P.M.; Saturday, 2.30 P.M.
WESTMINSTER HOSPITAL.—Operations, 2 P.M.
WEST LONDON HOSPITAL.—Operations, 2.30 P.M.
ST. MARY'S HOSPITAL.—Operations, 1.30 P.M. Consultations, Monday, 2.30 P.M. Skin Department, Monday and Thursday, 9.30 A.M.
ROYAL INSTITUTION.—3 P.M. Mr. Walter Gardiner: The Plant in the War of Nature.
SOCIETY OF ARTS.—8 P.M. Mr. J. D. Crace: The Decorative Use of Colour.
THE PARKES MUSEUM OF HYGIENE.—8 P.M. Mr. J. F. J. Sykes: General Powers and Duties of Inspectors of Nuisances; Method of Inspection.
ROYAL MEDICAL AND CHIRURGICAL SOCIETY.—8.30 P.M. Dr. C. Theodore Williams: On the Results of the Treatment of Pulmonary Consumption by Residence at High Altitudes, as exemplified by an Analysis of 141 cases.—Dr. Percy Kidd and Mr. H. H. Taylor: On the Value of the Tubercle Bacillus in Clinical Diagnosis.

Wednesday, May 9.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.
MIDDLESEX HOSPITAL.—Operations, 1 P.M.
ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1.30 P.M.; Saturday, same hour. Ophthalmic Operations, Tuesday and Thursday, 1.30 P.M. Surgical Consultations, Thursday, 1.30 P.M.
ST. THOMAS'S HOSPITAL.—Operations, 1.30 P.M.; Saturday, same hour.
LONDON HOSPITAL.—Operations, 2 P.M.; Thursday & Saturday, same hour.
GREAT NORTHERN CENTRAL HOSPITAL.—Operations, 2 P.M.
SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2.30 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; Saturday, 2 P.M. Skin Department, 1.45 P.M.; Saturday, 9.15 A.M.
ROYAL FREE HOSPITAL.—Operations, 2 P.M., and on Saturday.
KING'S COLLEGE HOSPITAL.—Operations, 3 to 4 P.M.; Friday, 2 P.M.; Saturday, 1 P.M.
CHILDREN'S HOSPITAL, GREAT ORMOND-ST.—Operations, 9 A.M.; Saturday, same hour.
EPIDEMIOLOGICAL SOCIETY OF LONDON.—8 P.M. Dr. B. A. Whitelegge: Age, Sex, and Season in relation to Scarlet Fever.
ROYAL MICROSCOPICAL SOCIETY.—8 P.M. Dr. A. C. Stokes: New Infusoria Flagellata from American Fresh-waters.
SOCIETY OF ARTS.—8 P.M. Mr. Samuel Chatwood: Locks and Safes.
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(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, May 3rd, 1888.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Dry Bulb.	Wet Bulb.	Solar Radia in Vacuo.	Max. Temp. Shade.	Min. Temp	Rain fall.	Remarks at 9.30 A.M.
Apl. 27	30·16	N.W.	43	39	95	58	35	...	Cloudy
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LATE CLINICAL ASSISTANT, WESTERN OPHTHALMIC HOSPITAL.

April 28th, 1888.

A NEW FORM OF COFFIN.

WE have received a model of a metallic coffin devised by Dr. Guilleret, the aim of which appears to be to provide against premature interment. Fitted into the lid, and just where the mouth of the body would be, is a small circular piece of glass or window, which would be moved by the slightest attempt to breathe, and thus facilitate the admission of air, whilst it would show on the surface by condensation the existence within the coffin of vapour arising from respiration. It also appears, from the statements made by a deputation which waited upon us (including Dr. Guilleret), that the coffin is intended to serve another purpose—viz., to prevent the escape of noxious gases from the corpse in the interval between death and burial. This, which it seems is the main object of the coffin, is effected by the arrangement of the lid, which, unlike that of the ordinary wooden coffin, fits into a groove intended to contain some impermeable substance, so as effectually to prevent any escape of effluvium. While admiring the ingenuity of the invention, we must confess to a preference for a more perishable coffin. The use of that most admirable deodoriser, wood charcoal, will with a perishable coffin meet any case of rapid decomposition, and be more in accordance with the principles of modern sanitary burial than any metallic coffin, however perfect.

Dr. A. Chadwick.—Mr. Lewis did not publish any Digest of the English Census Report in 1881. The Census Report itself is, however, published by Messrs. Eyre and Spottiswoode, Queen's Printers (and may be ordered through any bookseller), in a manner and at a price to suit the requirements of the public. The General Report (vol. iv., price 1*s.* 4*d.*) contains the report and the general results for England and Wales compared with those obtained at preceding censuses. Divisional Part No. 8 contains the whole of the statistics for Lancashire and Cheshire, and is published separately, price 1*s.* 7*d.*

Mr. H. H. Sturge.—The matter shall receive attention next week.

Dr. J. L. Steven's suggestion shall be kept in view.

WANTED, A DIAGNOSIS.

To the Editors of THE LANCET.

SIRS,—Will you kindly allow me space in your next issue, as I wish to call the attention of the profession to the case of Mrs. ——, a very near relative of mine. Mrs. —— is about sixty years of age, and the mother of seven children, all of whom are alive and healthy. She has always enjoyed good health, and has never suffered from any complaints whatever, except an attack of typhoid fever about four years ago, which debilitated her very much for a time, but she afterwards became quite well. She has had three brothers and three sisters, all of whom were exceedingly healthy and strong, robust people. One brother died about six years ago at about the age of fifty, from, I believe, the same complaint from which she is now suffering, and was always very healthy until twelve months previously to his death, when his symptoms became quite the same. I may mention that Mrs. —— has always been a very active and exceptionally smart woman in whatever business she undertook, and was accustomed to manage all the affairs of her household for upwards of twenty-five years. About six months ago she began to suffer from restlessness, and to imagine that all her affairs were going to ruin, and that she would come to poverty. She could not rest night or day, moving and throwing about her arms and rubbing her hands. She cannot keep still for more than a few minutes at a time, but can control herself and talk as sensibly as anyone when she comes in contact with a stranger. No one outside her own household can notice anything the matter with her, but she is always afraid of their doing so, and but for her bodily weakness she could attend to her household duties as well as she ever could have done; but when alone she sighs and moans heavily, talks to herself, and complains of very severe pain on the top of the head. There has never been the slightest trace of insanity in any member of her family. She can talk quite rationally when conversing with anyone; she never says a word out of place. I gave her bromides for some time. Besides, I took her to a medical friend of my own, and he recommended the same with strychnine. She improved slightly and became quite calm for a time, but the effect has passed off, and she is now as bad as ever, and is, I believe, getting worse daily, although, as I have above stated, she can temporarily control herself. These are the symptoms as near as I can give them.

If any medical brother can give me any information as to the true nature of the disease and the treatment he would recommend, I shall be for ever obliged. I remain, Sirs, yours faithfully,

May 1st, 1888. SUBSCRIBER.

EXEMPTION FROM SERVING ON JURIES.

To the Editors of THE LANCET.

SIRS,—You would, I am sure, confer a great favour on the profession if you could inform us to whom we are to apply in order to express a "desire" that we may be exempted from serving on a jury.

I am, Sirs, yours obediently,

April 28th, 1888. A MEDICAL MAN IN ACTIVE PRACTICE.

*** Our correspondent should communicate with the overseers or vestry clerk of his district. The present is, we believe, about the time of year when jury lists are under consideration.—ED. L.

DEATH REGISTRATION.

X. Y. Z.—By the Births and Deaths Registration Act, 1874, a registrar upon registering a death is not only authorised but is also required "to give, without fee or reward, either to the person giving information concerning the death or sending the requisition or notice, or to the undertaker or person having charge of the funeral of the deceased, a certificate under his hand that he has registered or received notice of the death, as the case may be." Such a certificate, therefore, he has legal power to issue in the circumstances set out in our correspondent's letter. But we much doubt his authority to enter inflammation of the bowels as the cause of death. In the Schedule (B) to the Act of 1836 the cause of death is left blank in the exemplary entry there given, with the manifest intention of indicating that it is to be filled up only when adequate information is forthcoming, and may in a suitable case be left blank, as in the example. For the supplying of this information the Act of 1874 makes provision by casting upon the medical man who attends at the last illness the duty of giving a certificate as to the cause of death, and then enacting that "the cause of death as stated in that certificate shall be entered in the register, together with the name of the certifying medical practitioner." There does not appear to be anywhere an express prohibition of the entry of the cause of death on any other authority, but it may fairly be considered that the object of the Legislature was to replace the more or less worthless speculations of relatives as to the cause of death by exact scientific testimony. If this view should prevail, and we are not aware that it has ever yet been discussed in a court of law, it would seem to follow that the registrar in question has exceeded his powers by entering the cause of death.

Duz might consult the Medical Directory.

"HARD TIMES IN THE PROFESSION."

To the Editors of THE LANCET.

SIRS,—I quite agree with the letter of "Fairplay," in the current number of THE LANCET. If there is one pest more than another the medical practitioner has to put up with, it is the prescribing chemist. Within a radius of a few hundred yards of me there are at least half a dozen prescribing chemists, who not only prescribe for trifling ailments, but actually perform many small operations that certainly require a great deal more skill and knowledge in their performance than chemists usually possess. There is one chemist in particular in my district, who is known by many of the poor as the "Doctor." He goes through the regular consultation routine, feels the pulse, looks at the tongue, &c., and, as nature has endowed him with a long, patriarchal-looking white beard, he is all the more able to assume a look of a good, great, and wise man. And what makes it worse in this case is that he is not even a properly qualified chemist by examination, as, having kept a few bottles of drugs and scents before the Act came into force, he has now the privilege of calling himself chemist; but even this title does not seem to satisfy him. I quite agree that something should be done to put a stop to the prescribing of chemists. I am, Sirs, yours faithfully,

May, 1888. D.

"MATERNAL IMPRESSION."

To the Editors of THE LANCET.

SIRS,—In 1861, when at practice at Clapton, I delivered a woman of a monoculous fœtus. The mother at an early period of her pregnancy was struck between the eyes with a small eel, just caught by her boy in the Lea, which accidentally slipped from a piece of thread while the boy was slinging it round to show her, and to this she attributed the malformation. The specimen is now in the museum at Lincoln's Inn. Shortly after this I delivered a woman in the same neighbourhood of a two-headed monster, having three legs. This case was reported by the late Dr. Phillips in Guy's Reports. The mother attributed the abnormal birth to an impression made upon her some seven months previously when seeing the Siamese twins. A third case happened not long after this, when I delivered a woman of a full-time male child minus the left forearm. It appears that the mother had during her early pregnancy been an in-patient at a hospital, and had seen a recently-amputated forearm dressed daily in the bed adjoining hers.

These cases are, I think, fair evidence of the effects of maternal impression. I am, Sirs, yours faithfully,

Brighton, April, 1888. C. H. WELCH, F.R.C.S., &c.

THE LUCE FUND.

To the Editors of THE LANCET.

SIRS,—We beg leave to acknowledge, with many thanks, the receipt of £5 5*s.* from Dr. Carter of Liverpool, £1 1*s.* from Dr. Vacher of Birkenhead, £1 from Mr. H. O. Thomas of Liverpool, £1 from Dr. Drysdale of Liverpool, £1 from W. Collico, Esq., Oxford, and 1*s.* anonymously from Manchester.

Mrs. Luce is a good teacher of music to advanced pupils. She would be very grateful for recommendations or employment from any Liverpool medical men.—We are, Sirs, yours faithfully,

W. T. SHEPPARD, M.D.,
64, Durning-road, Liverpool,
R. CATON, M.D.,
31, Rodney-street, Liverpool.

May 1st, 1888.

Medical Diary for the ensuing Week.

Monday, May 7.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10.30 A.M., and each day at the same hour.
ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1.30 P.M. and each day at the same hour.
CHELSEA HOSPITAL FOR WOMEN.—Operations, 2.30 P.M.; Thursday, 2.30.
ST. MARK'S HOSPITAL.—Operations, 2 P.M.; Tuesday, 2.30 P.M.
HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M., and on Thursday at the same hour.
METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.
ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
CENTRAL LONDON OPHTHALMIC HOSPITALS.—Operations, 2 P.M., and each day in the week at the same hour.
ROYAL INSTITUTION.—5 P.M. General Monthly Meeting.
ODONTOLOGICAL SOCIETY OF GREAT BRITAIN.—8 P.M. Dr. Edward Blake: On Dental Reflexes and Trophic Changes.—Mr. George Cunningham: On a Statistical Inquiry as to the Results of the Immediate Treatment of Pulpless and Abscessed Teeth.
SOCIETY OF ARTS.—8 P.M. Mr. G. Aitchison: Decoration. (Cantor Lecture.)
MEDICAL SOCIETY OF LONDON.—8.30 P.M. Sir Joseph Fayrer, K.C.S.I.: On the Natural History and Epidemiology of Cholera. (Annual Oration.) To be followed by a Conversazione.

Tuesday, May 8.

GUY'S HOSPITAL.—Operations, 1.30 P.M. and on Friday at the same hour. Ophthalmic Operations on Monday at 1.30 and Thursday at 2 P.M.
ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 4 P.M.; Friday, 2 P.M.
CANCER HOSPITAL, BROMPTON.—Operations, 2.30 P.M.; Saturday, 2.30 P.M.
WESTMINSTER HOSPITAL.—Operations, 2 P.M.
WEST LONDON HOSPITAL.—Operations, 2.30 P.M.
ST. MARY'S HOSPITAL.—Operations, 1.30 P.M. Consultations, Monday, 2.30 P.M. Skin Department, Monday and Thursday, 9.30 A.M.
ROYAL INSTITUTION.—3 P.M. Mr. Walter Gardiner: The Paint in the War of Nature.
SOCIETY OF ARTS.—8 P.M. Mr. J. D. Crace: The Decorative Use of Colour.
THE PARKES MUSEUM OF HYGIENE.—8 P.M. Mr. J. F. J. Sykes: General Powers and Duties of Inspectors of Nuisances; Method of Inspection.
ROYAL MEDICAL AND CHIRURGICAL SOCIETY.—8.30 P.M. Dr. C. Theodore Williams: On the Results of the Treatment of Pulmonary Consumption by Residence at High Altitudes, as exemplified by an Analysis of 141 cases.—Dr. Percy Kidd and Mr. H. H. Taylor: On the Value of the Tubercle Bacillus in Clinical Diagnosis.

Wednesday, May 9.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.
MIDDLESEX HOSPITAL.—Operations, 1 P.M.
ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1.30 P.M.; Saturday, same hour. Ophthalmic Operations, Tuesday and Thursday, 1.30 P.M. Surgical Consultations, Thursday, 1.30 P.M.
ST. THOMAS'S HOSPITAL.—Operations, 1.30 P.M.; Saturday, same hour.
LONDON HOSPITAL.—Operations, 2 P.M.; Thursday & Saturday, same hour.
GREAT NORTHERN CENTRAL HOSPITAL.—Operations, 2 P.M.
SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2.30 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; Saturday, 2 P.M. Skin Department, 1.45 P.M.; Saturday, 9.15 A.M.
ROYAL FREE HOSPITAL.—Operations, 2 P.M., and on Saturday.
KING'S COLLEGE HOSPITAL.—Operations, 3 to 4 P.M.; Friday, 2 P.M.; Saturday, 1 P.M.
CHILDREN'S HOSPITAL, GREAT ORMOND-ST.—Operations, 9 A.M.; Saturday, same hour.
EPIDEMIOLOGICAL SOCIETY OF LONDON.—8 P.M. Dr. B. A. Whitelegge: Age, Sex, and Season in relation to Scarlet Fever.
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WANTED, A DIAGNOSIS.

To the Editors of THE LANCET.

SIRS,—Will you kindly allow me space in your next issue, as I wish to call the attention of the profession to the case of Mrs. ——, a very near relative of mine. Mrs. —— is about sixty years of age, and the mother of seven children, all of whom are alive and healthy. She has always enjoyed good health, and has never suffered from any complaints whatever, except an attack of typhoid fever about four years ago, which debilitated her very much for a time, but she afterwards became quite well. She has had three brothers and three sisters, all of whom were exceedingly healthy and strong, robust people. One brother died about six years ago at about the age of fifty, from, I believe, the same complaint from which she is now suffering, and was always very healthy until twelve months previously to his death, when his symptoms became quite the same. I may mention that Mrs. —— has always been a very active and exceptionally smart woman in whatever business she undertook, and was accustomed to manage all the affairs of her household for upwards of twenty-five years. About six months ago she began to suffer from restlessness, and to imagine that all her affairs were going to ruin, and that she would come to poverty. She could not rest night or day, moving and throwing about her arms and rubbing her hands. She cannot keep still for more than a few minutes at a time, but can control herself and talk as sensibly as anyone when she comes in contact with a stranger. No one outside her own household can notice anything the matter with her, but she is always afraid of their doing so, and but for her bodily weakness she could attend to her household duties as well as she ever could have done; but when alone she sighs and moans heavily, talks to herself, and complains of very severe pain on the top of the head. There has never been the slightest trace of insanity in any member of her family. She can talk quite rationally when conversing with anyone; she never says a word out of place. I gave her bromides for some time. Besides, I took her to a medical friend of my own, and he recommended the same with strychnine. She improved slightly and became quite calm for a time, but the effect has passed off, and she is now as bad as ever, and is, I believe, getting worse daily, although, as I have above stated, she can temporarily control herself. These are the symptoms as near as I can give them.

If any medical brother can give me any information as to the true nature of the disease and the treatment he would recommend, I shall be for ever obliged. I remain, Sirs, yours faithfully,

May 1st, 1888. SUBSCRIBER.

EXEMPTION FROM SERVING ON JURIES.

To the Editors of THE LANCET.

SIRS,—You would, I am sure, confer a great favour on the profession if you could inform us to whom we are to apply in order to express a "desire" that we may be exempted from serving on a jury.

I am, Sirs, yours obediently,

April 28th, 1888. A MEDICAL MAN IN ACTIVE PRACTICE.

*** Our correspondent should communicate with the overseers or vestry clerk of his district. The present is, we believe, about the time of year when jury lists are under consideration.—ED. L.

DEATH REGISTRATION.

X. Y. Z.—By the Births and Deaths Registration Act, 1874, a registrar upon registering a death is not only authorised but is also required "to give, without fee or reward, either to the person giving information concerning the death or sending the requisition or notice, or to the undertaker or person having charge of the funeral of the deceased, a certificate under his hand that he has registered or received notice of the death, as the case may be." Such a certificate, therefore, he has legal power to issue in the circumstances set out in our correspondent's letter. But we much doubt his authority to enter inflammation of the bowels as the cause of death. In the Schedule (B) to the Act of 1836 the cause of death is left blank in the exemplary entry there given, with the manifest intention of indicating that it is to be filled up only when adequate information is forthcoming, and may in a suitable case be left blank, as in the example. For the supplying of this information the Act of 1874 makes provision by casting upon the medical man who attends at the last illness the duty of giving a certificate as to the cause of death, and then enacting that "the cause of death as stated in that certificate shall be entered in the register, together with the name of the certifying medical practitioner." There does not appear to be anywhere an express prohibition of the entry of the cause of death on any other authority, but it may fairly be considered that the object of the Legislature was to replace the more or less worthless speculations of relatives as to the cause of death by exact scientific testimony. If this view should prevail, and we are not aware that it has ever yet been discussed in a court of law, it would seem to follow that the registrar in question has exceeded his powers by entering the cause of death.

Dux might consult the Medical Directory.

"HARD TIMES IN THE PROFESSION."

To the Editors of THE LANCET.

SIRS,—I quite agree with the letter of "Fairplay," in the current number of THE LANCET. If there is one pest more than another the medical practitioner has to put up with, it is the prescribing chemist. Within a radius of a few hundred yards of me there are at least half a dozen prescribing chemists, who not only prescribe for trifling ailments, but actually perform many small operations that certainly require a great deal more skill and knowledge in their performance than chemists usually possess. There is one chemist in particular in my district, who is known by many of the poor as the "Doctor." He goes through the regular consultation routine, feels the pulse, looks at the tongue, &c., and, as nature has endowed him with a long, patriarchal-looking white beard, he is all the more able to assume a look of a good, great, and wise man. And what makes it worse in this case is that he is not even a properly qualified chemist by examination, as, having kept a few bottles of drugs and scents before the Act came into force, he has now the privilege of calling himself chemist; but even this title does not seem to satisfy him. I quite agree that something should be done to put a stop to the prescribing of chemists. I am, Sirs, yours faithfully,

May, 1888. D.

"MATERNAL IMPRESSION."

To the Editors of THE LANCET.

SIRS,—In 1861, when at practice at Clapton, I delivered a woman of a monoculous fœtus. The mother at an early period of her pregnancy was struck between the eyes with a small eel, just caught by her boy in the Lea, which accidentally slipped from a piece of thread while the boy was slinging it round to show her, and to this she attributed the malformation. The specimen is now in the museum at Lincoln's Inn. Shortly after this I delivered a woman in the same neighbourhood of a two-headed monster, having three legs. This case was reported by the late Dr. Phillips in Guy's Reports. The mother attributed the abnormal birth to an impression made upon her some seven months previously when seeing the Siamese twins. A third case happened not long after this, when I delivered a woman of a full-time male child minus the left forearm. It appears that the mother had during her early pregnancy been an in-patient at a hospital, and had seen a recently-amputated forearm dressed daily in the bed adjoining hers.

These cases are, I think, fair evidence of the effects of maternal impression. I am, Sirs, yours faithfully,

Brighton, April, 1888. C. H. WELCH, F.R.C.S., &c.

THE LUCE FUND.

To the Editors of THE LANCET.

SIRS,—We beg leave to acknowledge, with many thanks, the receipt of £5 5*s.* from Dr. Carter of Liverpool, £1 1*s.* from Dr. Vacher of Birkenhead, £1 from Mr. H. O. Thomas of Liverpool, £1 from Dr. Drysdale of Liverpool, £1 from W. Collico, Esq., Oxford, and 1*s.* anonymously from Manchester.

Mrs. Luce is a good teacher of music to advanced pupils. She would be very grateful for recommendations or employment from any Liverpool medical men.—We are, Sirs, yours faithfully,

W. T. SHEPPARD, M.D.,
64, Durning-road, Liverpool,
R. CATON, M.D.,
31, Rodney-street, Liverpool.

May 1st, 1888.

CONGENITAL GOITRE.

To the Editors of THE LANCET.

SIRS,—In THE LANCET of Feb. 25th, 1888, Mr. George H. Ormsby of Slaidburn describes a case of congenital goitre which, in being inherited from a goitrous mother who seemed to expect that her child would be born with the disease, resembles a case of the same affection which I treated successfully in 1883, and an account of which was published in the *New York Medical Record* of Dec. 29th, 1883. I followed the general directions given in Aitken's "Science and Practice of Medicine" for the external use of mercuric biniodide, by which he claims that wonderful success was obtained in India in the treatment of goitre. I used an ointment composed of ten grains of mercuric biniodide and an ounce of lard. The cure was effected in a day by two applications of this ointment, each application having been immediately followed by exposure of the anointed part to the sun, as directed by Prof. Aitken. The cure was complete and permanent. I have seen the child recently. He is now nearly five years old, and remains free from any trace of goitre. At birth the goitrous tumour was as large as a hen's egg, and had grown larger when the child was four months old, the age at which the cure was accomplished.

I am, Sirs, yours respectfully,

J. C. WORTHINGTON, M.D.,
Captain and Assistant Surgeon, U.S. Army.

Fort Crawford, Uncompahgre, Colorado, March 27th, 1888.

A NEW FEEDING FUNNEL.

To the Editor of THE LANCET.

SIRS,—Mr. Barnes' feeding funnel with an aperture at the top and a lid is undoubtedly an improvement on the ordinary apparatus. But why not have the lid made of glass, as in the Paley's feeder? Or, better, why not make the funnel and lid both of glass, so that the operator can more easily see the liquid gravitating into the stomach? Mr. Barnes' stopcock is not new. Messrs. Weiss have made me funnels with stopcocks for some years. As a feeder myself, I can endorse Mr. Barnes' remark on the disagreeableness of having liquid food spilt over the doctor or the attendants. While on the subject, may I mention that if mouth feeding fail's to disgust a patient I am in the habit of using a nasal tube on a Higginson's syringe? After one such operation the patient usually takes food in a natural manner.

I am, Sirs, your obedient servant,

Richmond-terrace, S.W., April 28th, 1888. HENRY SUTHERLAND.

THE MARSHALL AND SHAW FUND.

To the Editors of THE LANCET.

SIRS,—Will you kindly acknowledge this additional list of subscriptions to the Marshall and Shaw fund. The list will be closed on Saturday, May 12th.

We are, Sirs, yours faithfully,

J. MICHELL CLARKE } Hon. Secs.
W. H. HARSANT, }

Clifton, May 1st, 1888.

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"AN APPEAL."

To the Editors of THE LANCET.

SIRS,—The following subscriptions have been received in addition to those announced in your issue of the 21st ult.

I am, Sirs, faithfully yours,

May 1st, 1888. H. WILSON REED, M.D.

A Sympathiser ...	£10	0	0	Sir Prescott Hewett, Bt.	£2	0	0
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COMMUNICATIONS not noticed in our present number will receive attention in our next.

COMMUNICATIONS, LETTERS, &c., have been received from — Sir W. Mac Cormac, London; Dr. W. H. King, Chester; Mr. F. T. Simson, London; Dr. A. H. Robinson, London; Mr. W. Anderson, London; Mr. Ohlson, London; Mrs. J. Butler, London; Messrs. Richardson and Co., London; Dr. H. W. Reed, Broadstairs; Dr. H. Sutherland, London; Prof. Richet, Paris; Dr. Sandwith; Mr. J. H. Jones, Wilkes Barré; Dr. C. R. Drysdale, London; Mr. C. J. Smith; Dr. Gibbings, London; Mr. Ashby, Reading; Mr. Hughes, London; Mr. J. A. Lane, London; Dr. Myrtle, Harrogate; Dr. Cheadle; Mr. Mansell Moullin, London; Dr. Auvard; Dr. Park, Glasgow; Mr. Conder; Dr. Lindsay Steven, Glasgow; Dr. Goude, London; Mr. Llewellyn, Tunbridge Wells; Dr. J. M. Gibbes, Taranaki; Mr. Purnell, Geelong; Mr. E. G. Dutton, Plymstock; Mr. C. H. Welch, Brighton; Dr. Wiglesworth, Liverpool; Mr. F. Marsh, Birmingham; Messrs. Mottershead and Co., Manchester; Dr. Collins, Manchester; Messrs. Reynolds and Branson, Leeds; Dr. Brailey, London; Mr. Lee, Leeds; Mr. Mercier, London; Dr. Garry, Liverpool; Mr. H. Godrich, Surbiton; Mr. Abbs, Dewsbury; Dr. Tate, Notts; Mr. Jones, Bristol; Mr. R. Hordley, Staffs; Mr. Green, Droitwich; Dr. Rudyer, Homburg; Mr. Morgan, Carmarthen; Medicus; The Matron, Stockport; D.; R. M.; Sanitas; X. Y. Z.

LETTERS, *each with enclosure*, are also acknowledged from—Mr. Oscar, London; Mr. Elliot, Devon; Dr. Dunn, Lancashire; Mr. Bickerton, London; Mr. Schall, London; Mr. Phillips, London; Mr. Wingrave, London; Mrs. Peel, London; Mr. Beckton, London; Mr. McEwan; Mr. Strutt, Streatham; Mr. Popham, Salop; Messrs. Thomson and Son, Luton; Mr. Heywood, Manchester; Mr. Wormald, Manchester; Messrs. Moore and Co., London; Mr. Bliss, Watford; U., Liverpool; S. T., London; Remo, London; J. G. B., London; Whittington Life Assurance Co., London; Lindlum, London; Sigma, London; Beech Hurst, Hanley; Owner, Watford; Medicus, London; X. O.; Bona Fides; Felicitas, London; Fibula, London; F. A., London; G. P., London; W. M. W., Chesterfield; L., Wimbledon; F. M., Birkenhead; D. A. H., London; Buckingham; A. S. A., London; Howard, London; M.D., Crewe; Medicus, Manchester; Chester Diocesan Deaconess' Institution; M. C. M., London; Omega, London; Mica, London; Graduate, London; Medicus, Waterloo; M., London; S. B., Clapham.

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